ADMIN 262

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

Office Memorandum

TO : Dr. Gallese

DATE: January 31, 1966

FROM : Edith Stelljes

SUBJECT: Federal Grant

The following grant has been returned to us approved by the Dept. of Administration and is being forwarded to you for proper distribution.

BRAINERD STATE SCHOOL & HOSPITAL

Intensive Habit Training of Severely Retarded Adults

$100,000.00

ES:jf Edith

66-IHT-B55

Dr Wallace

(Leave Blank)
R'cd date
Council
Action

U. S. Department of H I P
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

APPLICATION FOR MENTAL HEALTH PROJECT GRANT

(A PRIVILEGED COMMUNICATION)

(Leave Blank)
No.
SS MHPG
Formerly

Application is hereby made for a grant in the amount and for the period stated, for the purpose of conducting a mental health project as described herein, in accord with the Agreement signed below.

A. AMOUNT REQUESTED: $ 100,000.00 (Same as total of itemized budget, page 2, item A8.)

B. PERIOD DATES: June (Mo.) 1 (Day) 1966 (Year) thru May (Mo.) 31 (Day) 1967 (Year) (Normally 12 months. See instructions.)

C. TITLE OF PROPOSAL (Do not exceed 53 typewriter spaces)
Intensive Habit Training of Severely Retarded Adults

D. TYPE OF APPLICATION (please check one only, and add No. if applicable): ☒ New Project Proposal;
or ☐ Revision of, ☐ Supplement to, or ☐ Renewal of PHS application or grant No. _____

E. PROGRAM DIRECTOR:
Name Harold W. Peterson Telephone No. 829-2845 Extension 200
Title Administrator Department or Service Administrative
Mailing address Box 349, Brainerd State School and Hospital, Brainerd, Minnesota
Institution Brainerd State School and Hospital Major Sub Division

F. CO-DIRECTOR, if any. (Name and title only)
David Willenson, Ph.D. Tel. 829-2845 - Ext. 215
Chief Psychologist Dept. - Psychology
Box 349, Brainerd State School and Hospital, Brainerd, Minnesota

G.

INSTITUTION SPONSORING REQUEST	H. NAME, TITLE, AND ADDRESS OF FINANCIAL OFFICER:
Name Brainerd State School & Hospital Mail address Box 349, Brainerd, Minnesota	State Treasurer of Minnesota c/o C. G. Chapado 5th Floor, Centennial Building St. Paul 1, Minnesota
Name & title of official authorized to sign application on behalf of institution. Harold W. Peterson, Administrator	Manner in which check(s) should be drawn: Minnesota State Treasurer

I. AGREEMENT: It is understood and agreed by the undersigned that any grant received as a result of this application is subject to the following terms: (1) Funds granted as a result of this request are to be expended for the purposes set forth herein as governed by Public Health Service and grantee institution policies; (2) the grant may be revoked in whole or in part at any time by the Surgeon General of the Public Health Service, provided that a revocation shall not include any amount obligated previous to the effective date of the revocation if such obligations were made solely for the purposes set forth in this application; (3) all reports of original investigations supported by the grant shall acknowledge such support; (4) if any invention arises or is developed in the course of the work aided by the grant, the undersigned will either (a) refer to the Surgeon General for determination, or (b) determine in accordance with grantee institution's own policies as formally stipulated in a separate supplementary agreement entered into between the Surgeon General and the grantee institution, whether patent protection on such invention shall be sought and how the rights in the invention, including rights under any patent issued thereon, shall be disposed of and administered, in order to protect the public interest.

J. PERSONAL SIGNATURES (in ink)
(1) Program Director Harold W. Peterson 1-24-66
(Same as shown in "E" above) (date)
(2) Authorized official of applicant institution Harold W. Peterson, Adm. 1-24-66
(Same as shown in "G" above) (date)

Mail completed application to:
National Institute of Mental Health
National Institutes of Health
Bethesda 14, Md.

Appr'd by Dept of Adm - 1/27/66

Budget Bureau No. 68-R618
Approval Expires May 31, 1964

OM-

OTHER SUPPORT: List support from all sources (past, present or pending) FOR THIS PROJECT, including any from the Public Health Service and from own institution. If none, so indicate.

SOURCE OF SUPPORT	TITLE OR IDENTIFICATION OF PROJECT	AMOUNT	PERIOD OF SUPPORT
	none		

TYPE OF AGENCY OR INSTITUTION:

(Check appropriate box)

- [X] State
- [ ] County
- [ ] Municipal
- [ ] Private, non-profit
- [ ] Voluntary
- [ ] Other *(Specify)*_____

RELATIONSHIP TO STATE PROGRAMS

A. Is the agency or institution submitting this application operated, supported, or supervised by an official State agency? . . . . . [X] Yes [ ] No

If "Yes," - 1. What is the State Agency? Minnesota Department of Public Welfare

2. What is the applicant's relationship to it? A state institution for the retarded controlled by the above department.

3. Is the State agency aware that this application for Federal funds is being made? . . . . . [X] Yes [ ] No

Comments:

B. Is there a State agency (other than the one named in A above) whose program is functioning in the same area or in an area related to your proposal? . . . . . [ ] Yes [X] No

If "Yes," - 1. What is the State agency? _____

2. Is this agency aware of the proposed project? . . . . . [ ] Yes [ ] No

Comments:

C. What will be the relationship of this project to current or proposed official State or local mental health program? This project is aimed toward implementation of planning begun at the Lino Lakes meeting of the Administrators and Medical Directors of the state institutions for the retarded in 1964. This meeting set forth the new approaches to resident care listed on pages 24 and 25 of this application . There is a direct relationship between this official statement of organization and program planning and the aims of this project for Program 5, the Adult Motivation Program. Pages 28-31 of this application define more thoroughly the mechanism of program development. The proposals of this application to provide for behavioral modification of the adult severely and profoundly retarded through habit training are a definite additive phase in the implementation of the Lino Lakes planning for this large group of patients in Minnesota state institutions for the mentally retarded.

BUDGET - Continued

B. ESTIMATE OF TOTAL SUPPORT REQUESTED FOR THIS PROPOSED RESEARCH PROJECT — On Line 1, below, include category totals taken from the detailed budget on Page 2. Similar estimates for all succeeding years should be given, starting on Line 2. If support beyond the one year shown on Line 1 is not required, please enter word "None," on Line 2. **(NOTE: DO NOT USE** the lower part of each line which is prefixed **LB.** This should be **LEFT BLANK.**

	PERSONNEL	EQUIPMENT	SUPPLIES	TRAVEL	OTHER	SUBTOTAL DIRECT	INDIRECT COST	OTHER *(No indirect cost allowed)*	TOTAL
1.	87,667	492	1,000	400	1,910	91,469	8,531		100,000
LB									
2.	92,824	---	500	---	310	93,634	7,366		100,000
LB									
3.	96,700	---	500	---	310	97,510	2,490		100,000
LB									
4.									
LB									
5.									
LB									
6.									
LB									
7.									
LB									

C. BUDGET JUSTIFICATION: *(Use continuation pages as necessary)*

1. Personnel See pages 45-48 for justification of all personnel
2. Permanent Equipment We suffer from a sparcity of typewriters. We expect the Clerk Steno I of the project to do the typing necessary to build up a good reference library of articles dealing with operant conditioning and other forms of training techniques. She will also be required to type all reports of the project and to take care of correspondence which is bound to develop in connection with a project of this kind and great interest. She will need this typewriter since we have none other to release to the project.
3. Consumable Supplies This training project is based very considerably upon the idea of small rewards for the trainees. We regard that ample justification has been shown and would regard the $800 expenditure listed herein as an amount which may have to be supplemented from charitable funds through the Volunteer Services. See Supplementary letter discussing rewards.
4. Other Expense Consultants (3) at $100 per day. To possibly include the following men doing work in this field: A. Robert Orlando, Ph.D., Peabody College, Nashville, Tenn. B. Norman R. Ellis, Ph.D., University of Alabama, University, Alabama. C. Joseph Spradlin, Ph.D., Bureau of Child Research, University of Kansas, Parsons, Kansas.

   Institutions in Minnesota are required to pay .25¢ per paycheck to Central Services of the Department of Administration for Central IBM expense for payrolls paid out of federal grant funds. This accounts for the item "Payroll Tabulation Service".

   We suggest that the amount allowable for indirect cost be subject to negotiation on an annual basis - if this is possible.

5. Travel At both places listed, work is being done in related areas with the mentally retarded. Possibly with the use of one of our state cars we may manage these visits at this reasonable cost.

A. BUDGET REQUEST (for the period shown on page 1)

(1)	(2)	(3)
1. PERSONNEL List all positions, including Director and Co-Director. Amounts requested must not exceed proportion of total salary computed from % of time spent.	% time on this project	Requested from PHS (omit cents)
Harold W. Peterson, Administrator - Director	5%	----
David Willenson, Ph.D., Chief Clinical Psychologist -Co-director	10 %	$ ----
1 Research Analyst I (Coordinator) $468 - 569	100 %	5,730
19 Psychiatric Technician I 292 - 356	100 %	67,944
1 Clerk Stenographer I 270 - 329	100 %	3,306
SERA 5%	%	3,849
OASI 4.2%	%	3,310
Insurance $14 per month each	%	3,528
2. PERMANENT EQUIPMENT, itemize (see instructions)		
1 ea. Electrically operated typewriter, Selectric Model 723		$ 441
IBM Corporation		
w/one year service		37
w/one type element		14
3. CONSUMABLE SUPPLIES, itemize (see instructions)		
Office supplies		$ 200
Rewards to patients		800
4. TRAVEL, itemize (see instructions)		
To: (1) Parsons State Hospital & Training Center, Parsons, Kansas		$ 400
(2) Mount Pleasant State Home & Training School, Mount Pleasant, Michigan		
5. OTHER EXPENSE, itemize (see instructions)		
Rental of film		$ 50
Books & Texts		100
Consultants		1,500
Payroll Tabulation Service		260
6. TOTAL DIRECT COST REQUIREMENTS		$ 91,469
7. INDIRECT COST ALLOWANCE (The administrative official signing this application may request an amount for indirect costs. Review detailed instructions) (Round to low dollar)		$ 8,531
8. TOTAL BUDGET (Same as amount shown in item A, page 1)		$100,000

B. ESTIMATE OF SUPPORT REQUESTED FOR THE YEAR FOLLOWING THE BUDGET PERIOD ITEMIZED ABOVE. Applicants for 1-year grants should type the word "None" in space for TOTAL BUDGET shown below.

Personnel	Equipment	Supplies	Travel	Other	Total Direct Cost	Indirect Cost	TOTAL BUDGET
$ 92,824	$	$ 500	$	$ 310	$ 93,634	$ 7,366	$ 100,000

C. ADDITIONAL YEARS OF SUPPORT, beyond the 2 years covered above, if requested. Please show the TOTAL AMOUNTS required for each such additional year, including indirect cost allowance.

3. $ 100,000 4. $ ---- 5. $ ---- 6. $ ---- 7. $ ----

HOSPITAL IMPROVEMENT APPLICATION

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Table of Contents (Cont'd.)

HOSPITAL IMPROVEMENT APPLICATION

Brainerd State School and Hospital
Brainerd, Minnesota

I. Developmental History of Brainerd State School and Hospital.

A. Its Location in the State Of Minnesota and Reasons for this Choice.

Prior to 1951 the only state institutions in northern Minnesota were the Minnesota State Sanatorium and Fergus Falls and Moose Lake State Hospitals. None of these dealt in a primary way with the mentally retarded. In 1951 the State Legislature determined to build a state institution for the mentally retarded at Brainerd, Minnesota. Certain mentally retarded and/or epileptic patients had been institutionalized at Cambridge State School and Hospital and Faribault State School and Hospital, which were at very considerable distance from the further reaches of northern Minnesota. It was hoped that the building of the institution at Brainerd would alleviate this situation and create economical opportunities of travel and communication for parents. It was envisaged that those patients at Cambridge and Faribault who had original residence in the northern counties of Minnesota would be transferred eventually to Brainerd. This aim was virtually reached by November of 1965. In 1951, also, there was a waiting list of some 1400 and there were vigorous clamors from all over the state that the needs of this waiting list be met by an additional building program. This was particularly true since the rate of increase of the waiting list was almost fifty new names per month. Brainerd, a city of 12,600, was chosen as the site for the new institution because of its location in central Minnesota and its southern centralized location with respect to the northern counties of Minnesota.

B. Development of Brainerd State School and Hospital as a Physical Facility for the Care of the Retarded.

1. Distinctive Features.

There are distinctive features in the construction plan of Brainerd State School and Hospital. These may be enumerated as follows: (1) A preliminary plan was complete for the whole institution before construction began. Original thought was that this would become a 2000-bed institution. The general format of the preliminary plan has been followed ever since. (2) The institution does not have its own power plant except for standby power. The institution relies on the Minnesota Power and Light Company, through the City of Brainerd. (3) For water supply and sewage disposal, the institution is tied to the City of Brainerd. (4) With the exception of certain fuel oil requirements from time to time, natural gas for heating purposes is furnished through the pipeline of the Minnesota

Valley Natural Gas Company. (5) No farm was planned for this institution. Farms are gradually being phased out at most of the state institutions in Minnesota. (6) Except for the area around a single 90-bed patient building, there is no confining fence. (7) Throughout its history the institution has had only one architect. (8) There is no cemetery on the grounds of this institution.

2. Earliest Construction, 1955-56.

The 1953 Legislature appropriated $125,000 for the preparation of preliminary plans and for the purchase of land approximately one mile east of Brainerd. This acreage fronts Highway 18 and was acquired prior to 1957 for $6,000. A further 78 acres was obtained as a result of a $15,000 appropriation by the 1957 Legislature. This addition is a triangular section on the west side of the original tract and brings the campus acreage to 198.

The 1953 legislative session appropriated $1,675,000 for completion of final plans, for construction of a sanitary sewer pressure main and a water main from the hospital site to the City of Brainerd, and for the beginning of construction of the Hospital-Administration Building. By the fall of 1956, 11,400 feet of cast iron sewer pipe had been laid, connecting the site with the sewage-drainage system of Brainerd. On the opposite side of Highway 18, a 14-inch cast iron water line was extended 13,000 feet to Brainerd.

3. Administration-Hospital Building (Bldg. #1).

Construction funds were authorized for this building by the 1955 Legislature (part of $1,675,000); by the 1957 Legislature ($175,000); and by the 1959 Legislature ($490,000 for the completion of the last two wings and final equipping).

With the exception of the two final wings, the Administration-Hospital Building was ready for occupancy early in June, 1958. The first twenty residents were housed in this building in the early part of June, 1958. By September 15, 1958, the number housed had risen to 88 and it was this figure that constituted the population of Brainerd State School and Hospital for the next fifteen months.

With final completion of the last two wings, beds are afforded for 95 residents and, in addition, there is a ward set aside, totaling some 20 beds, for an infirmary.

At the present time there is one upstairs ward of severely retarded and physically handicapped residents who are bedfast; on the first floor we have the infirmary for the

acutely ill. There is one ward of Program 6 male patients on the first floor and the other wards upstairs are for Program 6 female residents. See Page 28 for definition of Program 6.

What was once intended to have become the surgery is now taken over by the nursing education training program and is used for clinical instruction.

The Administration-Hospital Building not only provides key offices for several of the staff, but it also houses the business office, a central sterile supply room, a physical therapy section, x-ray department, general laboratory, pharmacy, isolation rooms to care for patients suffering from communicable diseases, electrocardiology and electroencephalography.

It is well to recall that the 95 beds of the Administration-Hospital Building plus its infirmary have not in the past been counted in with the proposed 1000 beds of the total institution, since it had been thought that these beds would be used on a temporary basis as they are at the present time. As the need develops, it is important that we have a section of our institution which can be expanded for the purpose of infirmary or acute medical care problems, and this is the main purpose of this particular building. We intend to have this use expanded within the next two-year period.

4. The Service Building (Bldg. #2)

$3,146,000 was authorized by the 1957 Legislature for the construction and equipping of this building. Located in the building are the central heating plant, central kitchen, centralized refrigeration, bakery shop, employees' cafeteria, laundry, dry cleaning plant, sewing and clothing repair shop, patient clothing store, general maintenance shop, electronic maintenance shop, paint shop, central receiving and central storage, 12-car storage area and charitable gift clothing storage area.

In addition to the above, the following mechanical control systems are centralized in this building: 1. Stromberg System, providing automatic street and area lighting, synchronization of clocks, and remote restart of mechanical equipment of the extensive ventilation system. 2. An automatic alarm system covering stopped ventilation motors, water distribution, sewage pumps and warning signals for heating systems in Building 34 (Water Pumping Station) and in Building 36 (Sanitary Sewer Pumping Station). 3. Edwards automatic fire control stations in offices of the Plant Operations Superintendent in the maintenance shop, which will indicate date, time, and location of any fire in the institution buildings and is linked also with the Brainerd Fire Station.

5. Patient Building Construction.

Bldg. No.	Description	No. of Beds	Filled
5	Male Work Pt. Bldg., 2 floors, 3 wings; 2 & 4-bed wards	184	1959
6	Male Pt. Bldg., 3 separate 30-bed wards (partial wall subdivision of 6-6-3 bed groupings on each side of an aisle	90	1959
22	Female work pt. Bldg., 2 floors, 3 wings, 2 and 4-bed wards	184	1959
7	Male Pt. Bldg., 3 separate 36-bed wards (partial wall subdivision of 6-6-6 bed groupings on each side of an aisle).	108	1961
8	Male Pt. Bldg., 3 separate 36-bed wards, similar to #7	108	1961
20	Female Pt. Bldg., 3 separate 36-bed wards, similar to #7	108	1962
21	Female Pt. Bldg., 3 separate 36-bed wards	108	1962
9	Male Pt. Bldg., Similar to #7	108	1965
10	Male Pt. Bldg., Similar to #7	108	1965
17	Female Pt. Bldg., Similar to #7	108	1965
19	Female Pt. Bldg., Similar to #7	108	1964

In addition to the total of 1322 beds in the above list of regular patient buildings, we add 95 more beds in the Hospital-Administration Building, Bldg. #1, which beds are in present full use by Program 6 residents. There are, therefore, 1417 beds used by residents here other than for strictly infirmary use. We have set aside one wing of 20 beds in addition to all of the above beds in our Hospital-Administration Building for use of acutely ill residents. This is our infirmary. If we wish to add these beds to the count of possible bed capacity, we do have 1437 beds. We regard that as of November 25, 1965 we have 41 empty beds and these will be gradually filled from the waiting list. It is plain to see that we are coming close to our present capacity.

6. Connective Construction

Approximately 20% of the total cost of the building of this institution has been for what might be called connective construction. This includes over 3500 feet of tunnels connecting all buildings and through which run many lines for utilities. These include piping for high pressure steam, condensate return, cold and soft water piping, protective conduit for high and low voltage electric lines, wiring for street lighting, telephones, television, paging and broadcast communication and fire alarm.

Central to the water distribution system has been the completion of a 600,000 gallon water tank (#35) and the Water Pumping Station (#34). The Sanitary Sewer Pumping Station (#36) is connected by sanitary sewer pressure main to the City of Brainerd sewage disposal plant which was enlarged for this purpose at a state expense of $225,000.

Other features of connective construction have included grading of the site, street lighting, landscaping, roads, parking areas, sidewalks, curbing and gutters and extension of the sanitary sewer system and the storm water drainage system.

7. The Field House and Seven-Acre Outdoor Playfield.

The construction of the seven-acre outdoor playfield has been completed at a cost of some $85,000 and it has been in use for the last two summers. It provides for a great variety of outdoor activities. There is provision for a skating rink in this area. The field house is electrically heated and can be used for a number of patient activities in the winter as well as in the summer. The playfield is now directly connected by ramp and by doors to the School and Rehabilitation Therapies Building. This is, probably, one of the most completely and well equipped outdoor playfields that may be found at any institution for the retarded in the United States.

8. The School Department and Rehabilitation Therapies Building, (Bldg. #4).

Because of its great importance in the possible enrichment of our programs for patients, we are furnishing description of the School and Rehabilitation Therapies Building in greater detail. We introduce this by referring you to the gross type blueprints herein attached. This building was completed in November, 1965 and on November 22 employees began their move into this building. The uses of this building are being developed not only by the rehabilitation staff and the education staff, but also by the four program treatment teams that have been at work for some time in this institution.

Because this is the most interesting and original building

in the state institutions for the retarded in Minnesota, we include here a listing of its facilities.

In its greatest length, the building is 290 feet; in its greatest width, 168 feet. The area of the finished basement floor is 11,298 square feet; the area of its first floor is 35,302 square feet--making a total of 46,600 square feet in this building.

A study of the floor plans and a visit to this building will show that it includes the following facilities:

(1) The basement provides:

(a) A 58' x 76' activities room equipped for physical education. This room has equipment installed which includes jump boards, horizontal bars, climbing rope, climbing pegboard, adjusto-bars, training bags, chest pulleys, stall bars, horizontal ladder and striking bag. This room can also be used for large game activities and for dancing.

(b) A pool table room.

(c) Gymnasium locker and shower rooms for both male and female residents.

(d) A two-lane bowling alley.

(e) Ten storage areas, two of which will house the Civil Defense Hospital which we have had for some time. It will be housed in this building since, in the event of need, the gymnasium and stage furnish the best place in the institution for installation of an emergency hospital.

(2) First floor provides:

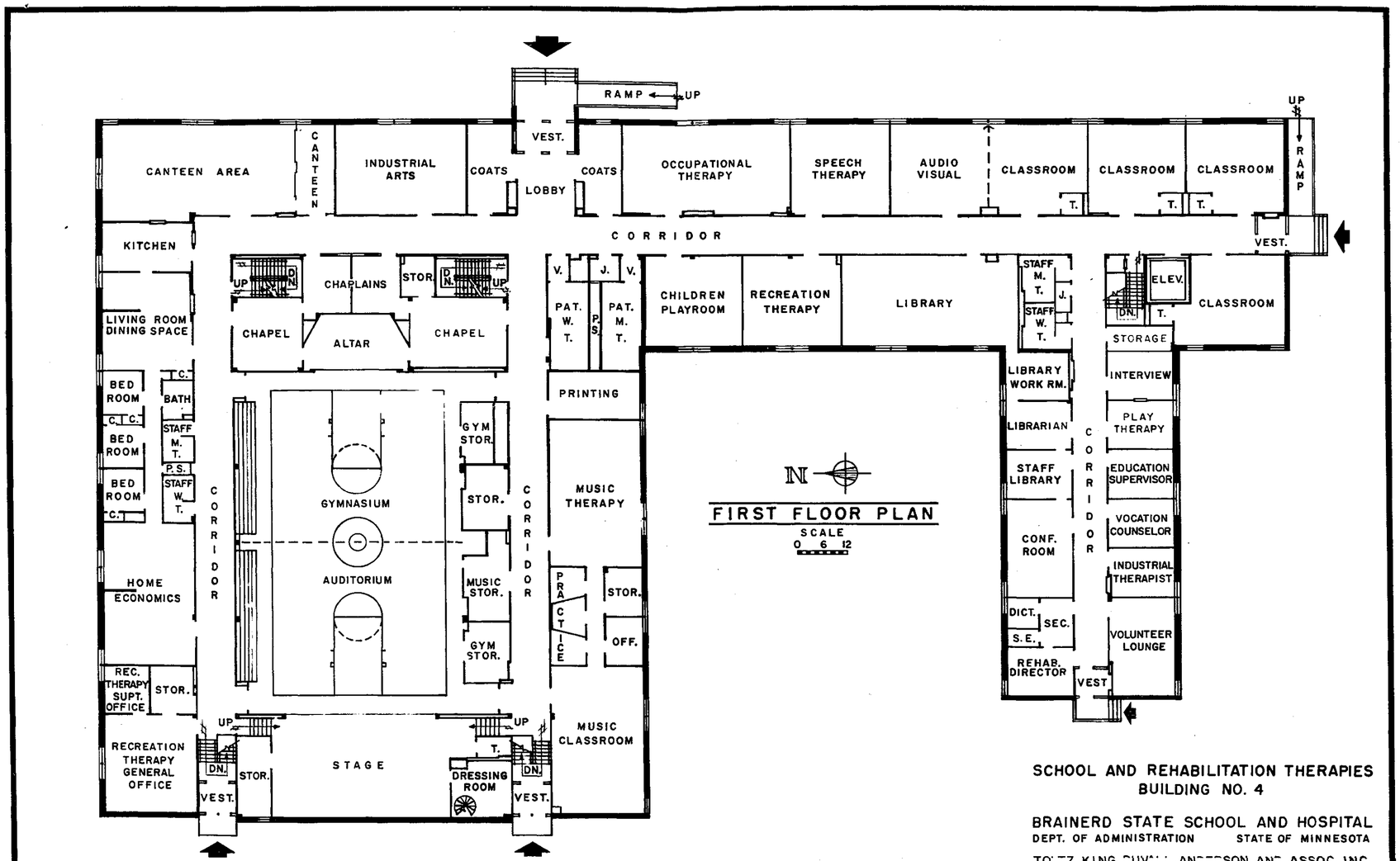
(a) Eight possible classrooms

(b) A patient and professional library area.

(c) Offices for staff, including offices for the Director of Rehabilitation Therapies and various staff counselors. It also includes a Volunteer Lounge and a conference room.

(d) A large music classroom and music therapy area.

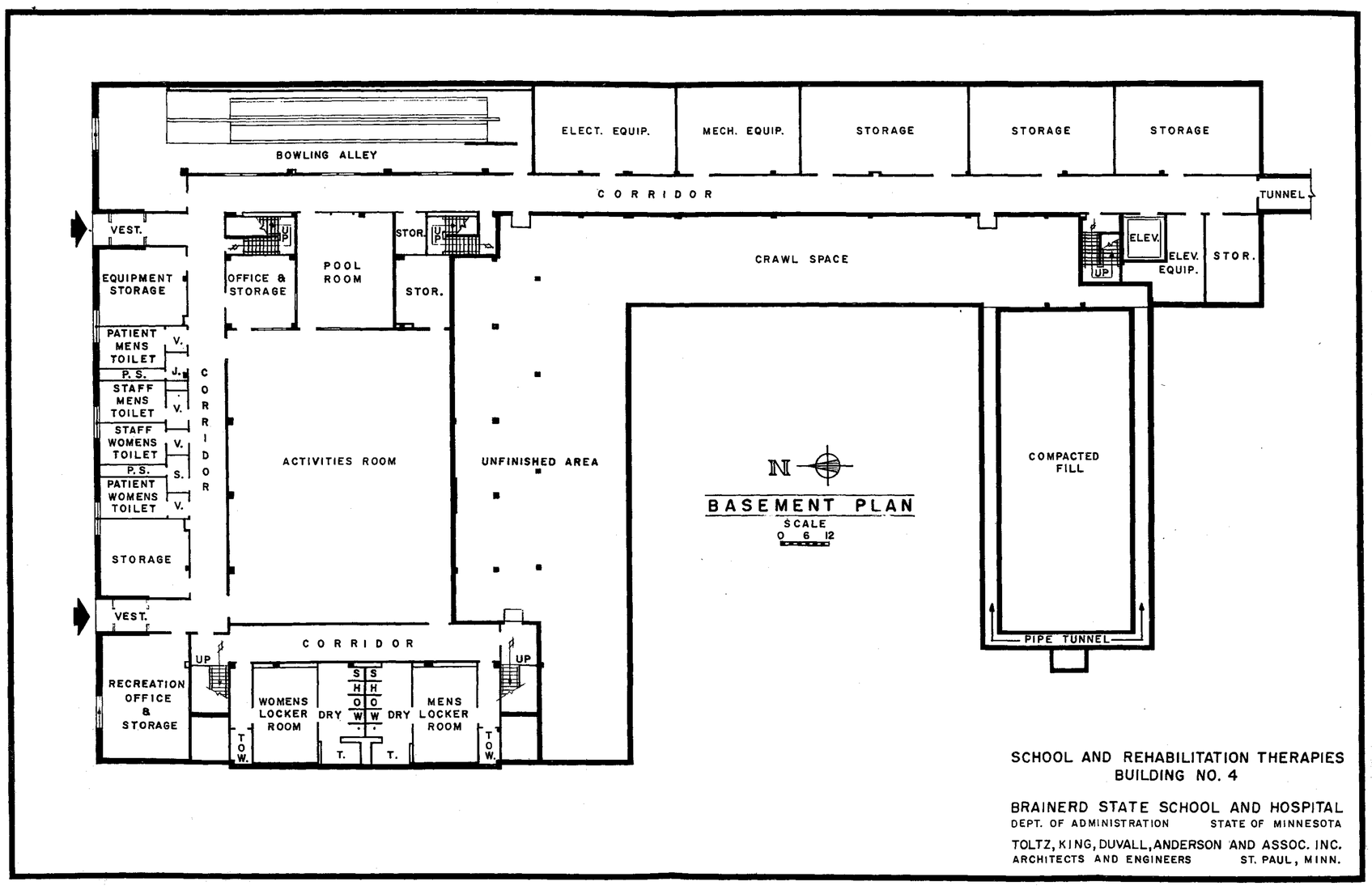
(e) Offices and chapels for two Chaplains; confessional and altar area. This faces the west end of the auditorium.



SCHOOL AND REHABILITATION THERAPIES
BUILDING NO. 4

BRAINERD STATE SCHOOL AND HOSPITAL
DEPT. OF ADMINISTRATION STATE OF MINNESOTA

TOMEZ, KING, DUVAL, ANDERSON AND ASSOC. INC.
ARCHITECTS AND ENGINEERS ST. PAUL, MINN.



SCHOOL AND REHABILITATION THERAPIES
BUILDING NO. 4

BRAINERD STATE SCHOOL AND HOSPITAL
DEPT. OF ADMINISTRATION STATE OF MINNESOTA

TOLTZ, KING, DUVALL, ANDERSON AND ASSOC. INC.
ARCHITECTS AND ENGINEERS ST. PAUL, MINN.

(f) A junior high school size gymnasium-auditorium. Holds 500; provided with bleacher seats for viewing competitive sports. Provision for basketball.

(g) A stage for programs and plays; dressing rooms. The stage faces the east end of the auditorium.

(h) An electrically operated dividing door which can cut the auditorium in half, and this might often be done for church services. It is also plain that this device can be used for carrying on two separate types of large scale activity programs at the same time.

(i) A fully equipped motion picture projection booth.

(j) Home economics area containing complete home living facilities and with a kitchen having a window to the canteen so it may serve the canteen upon occasion.

(k) A patients' canteen and store; to be operated by volunteers on a non-profit basis.

(l) An industrial arts area.

(m) An occupational therapy area.

(n) A duplicator or printing room.

(o) Offices for recreation people.

(p) Three intercom systems.

A ramp and doors in the basement furnish direct access to the seven-acre playfield for both ambulatory and wheelchair residents. It is also connected by tunnel with all of the other buildings on the campus. It has a single large size elevator which can be used for transport of wheelchair residents.

A very great use of this building is anticipated. The problems of its organization are great and its development will take place gradually in connection with the development of other programs throughout the institution. Not only will these programs be carried out in the School and Rehab Building and on the playfield, but also in the basement recreation areas and in the day rooms of the patient buildings. With adequate staffing and careful planning, programs for patients will become a basic and pervasive trademark of Brainerd State School and Hospital.

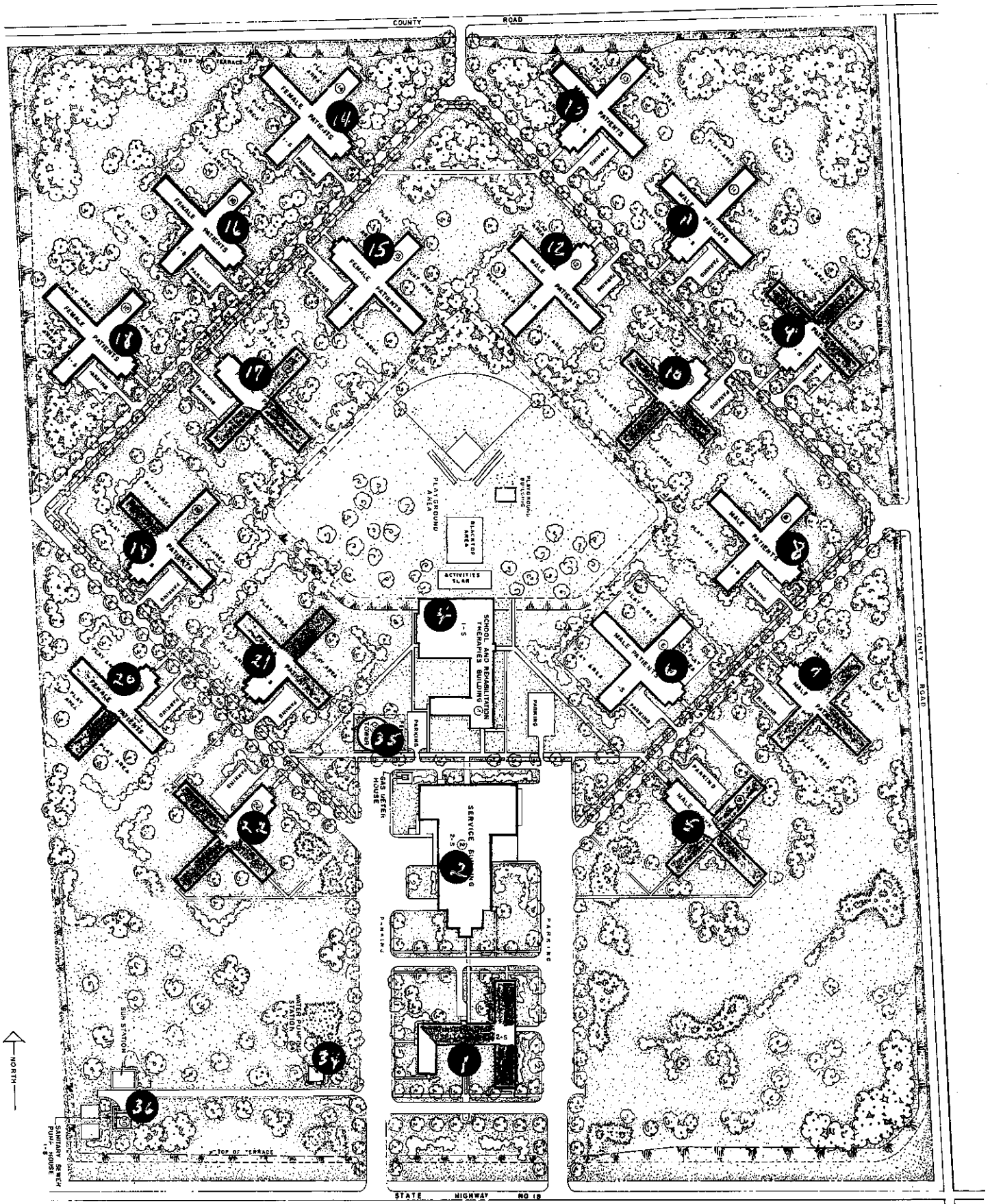
9. Summary of Legislative Building Appropriations, 1953-63.

Building Fund appropriations to Brainerd State School and Hospital by the Legislatures of 1953, 55, 57, 59, 61 and 63 are listed in the Ten-Year Statistical Summary of Legislative Building Appropriations, 1953-63, on Page 8

Summary of Legislative Building Appropriation, 1953-1963

Item No.	Bldg. No.	Item	1953	1955	1957	1959	1961	1963	Total
1		Site Purchase	6,000.		15,000.				21,000.
2		Preliminary Plans	119,000.						119,000.
3	1	Adm.-Hospital Bldg		1,675.000.	175,000.	490,000.			2,340,000.
4	2	Service Building			3,164,000.				3,164,000.
5	5	Male Work Patient Bldg.			935,000.	62,500.			997,500.
6	6	Male Patient Building			734,000.				734,000.
7	7	Male Patient Building				726,500.			726,500.
8	8	Male Patient Building				726,500.			726,500.
9	9	Male Patient Building					750,000.		750,000.
10	10	Male Patient Building					750,000.		750,000.
11	17	Female Patient Bldg.					750,000.		750,000.
12	19	Female Patient Bldg.					750,000.		750,000.
13	20	Female Patient Bldg.				726,500			726,500.
14	21	Female Patient Bldg.				726,500.			726,500.
15	22	Female Work Pt. Bldg.			935,000.	62,500.			997,500.
16	34	Water Pumping Station			42,000.				42,000.
17	35	Water Tank & Tower			183,000.				183,000
18	36	Sanitary Swr. Pump. Sta.			246,000.				246,000
19		Grading			175,000.		20,000.		195,000.
20		Street Lighting			25,000.	11,000	10,000.		46,000.
21		Landscaping			38,000.		8,000.		46,000.
22		Fences and Gates			18,000.	10,000.	5,000.		33,000.
23		Tunnels and Utilities			375,000.	195,000.	247,500.		817,500.
24		Sanitary Sewer System			145,000.		(		
25		Storm Water Drainage			212,000.		(77,000.		561,000.
26		Water Distribution			127,000.		(		
27		Seven Acre Playfield					30,000.		30,000.
28		Roads,Parking Areas,CG&S			90,000.	42,000.	30,000.		162,000.
29		State Share,enlarge Brainerd sewage disposal plant			212,000.				212,000.
30		Area dividers & equip.				15,000.			15,000.
31	3&4	School & Rehab. Bldg.						1,170,000.	1,170,000.
		Totals	125,000.	1,675,000.	7,846,000.	3,794,000.	3,427,500.	1,170,000.	$18,037,500.

Present Location of Patient Program Groups as of January 1, 1966



Completed construction

Recommended new construction

Recommend held in abeyance

PLOT PLAN
BRAINERD STATE SCHOOL AND HOSPITAL
BRAINERD, MINNESOTA
DEPARTMENT OF ADMINISTRATION — STATE OF MINNESOTA
KING, DUVALL, ANDERSON & ASSOCIATES, INC.
ENGINEERS AND ARCHITECTS ST. PAUL, MINNESOTA

Program 1-4
Program 2-3
Program 5
Program 6

It will be noted that appropriations to date equal $18,037,500.

The Plot Plan shown on Page 9 shows all resident and other buildings completed to date. The patient buildings are those which are colored in accordance with the program numbers of the patients living in the buildings. The Plot Plan included herein is quite self-explanatory.

10. Future Development.

At a meeting of the Interim Legislative Building Commission to be held here in the early quarter of 1966, we are intending to ask for two new buildings which might receive appropriation by the upcoming 1967 State Legislature. These are Buildings 12 and 15 on the Plot Plan. Please note their "inner circle" location.

It must be admitted that the future physical construction program at Brainerd State School and Hospital is in the grey areas of legislative decision for the future. Because of other developments in the programs for the mentally retarded throughout the state, programs which are not institutional, the need for future buildings cannot be as easily predicted as in the past. Many variables complicate the old-fashioned waiting list and projections of population on the basis of predictions made by the Minnesota Bureau of Vital Statistics. It is our growing feeling that future addition to buildings and the kinds of buildings will have to be justified on the basis of development of programs rather than on purely statistical bases in the future. This will be our approach in our upcoming presentation to the 1966 Interim Building Commission.

C. Growth of Number of Residents Between 6-16-58 and 11-30-65.

1. NUMBER OF RESIDENTS ON THE BOOKS
BRAINERD STATE SCHOOL AND HOSPITAL

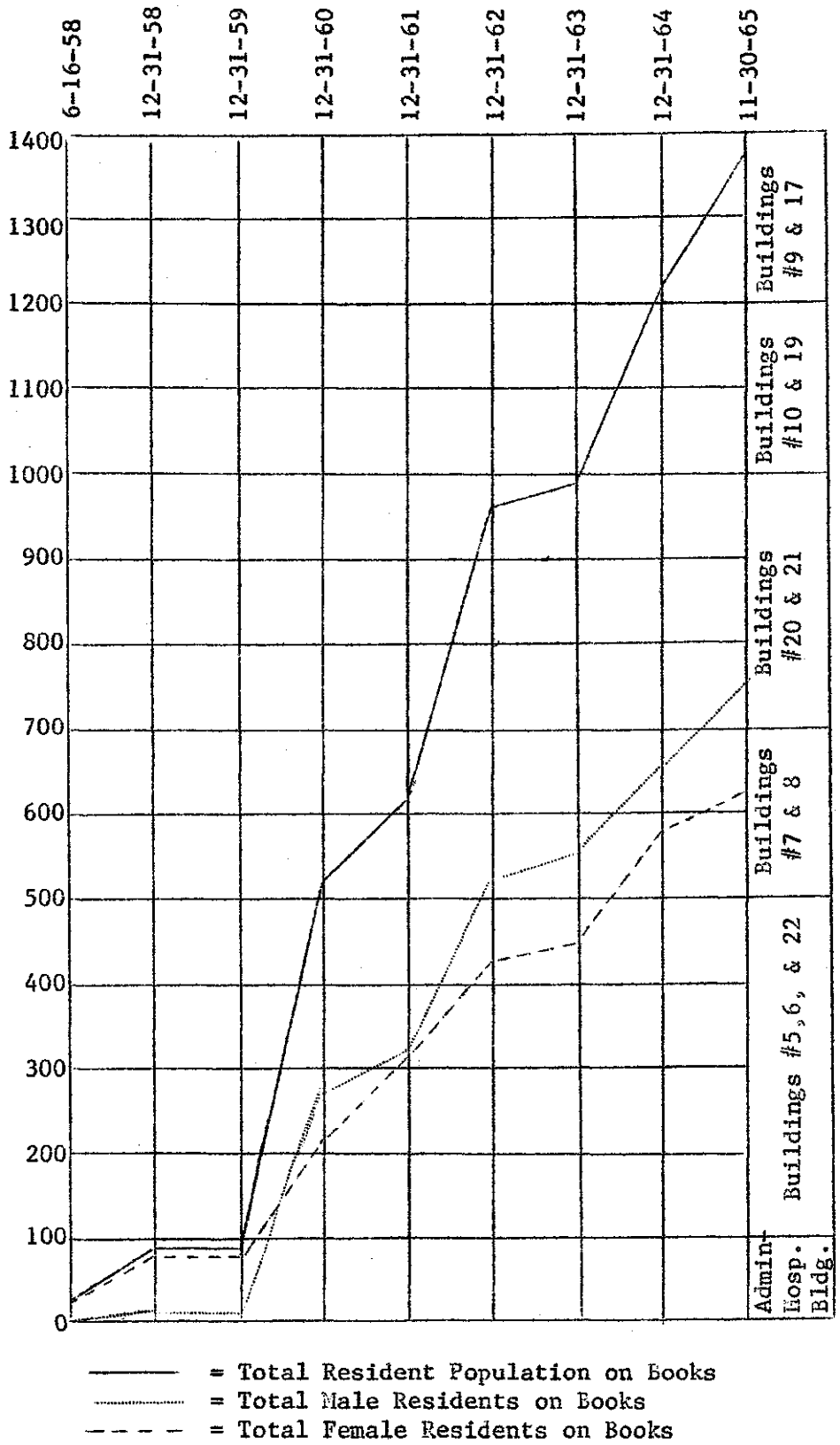
Date	Male	Female	Total
6-16-58		20	20
12-31-58	4	84	88
12-31-59	4	86	90
12-31-60	285	229	514
12-31-61	321	304	625
12-31-62	538	426	964
12-31-63	548	440	988
12-31-64	652	580	1232
11-30-65	754	626	1380

It may be kept in mind that the total number of residents on the books does not correspond with the number of residents in the institution at any one time. For instance, on 11-25-65 there were 1380 residents on the books, but of these 27 were on trial placement and 19 on extended vacations, which left a total number of patients in the institution of 1332.

A rather obvious observation may be made that there were, on 11-30-65, 128 more male residents on the books than females. This is reflected in the fact that we have six male resident buildings on the east side of the campus and five female residential buildings on the west side of the campus.

On basis of the above tabulation and the graph shown on Page 12, it is plain that Brainerd State School and Hospital is very close to full capacity. Upon no occasion has there been any overcrowding at Brainerd State School and Hospital. The standards of space demanded by the State Department of Health with respect to the areas of bed space and day room space have always been rigidly adhered to. The Central Office of the Department of Public Welfare, as well as the administration of this institution, have stood very firm on the standard that there must be no overcrowding at this institution. However, it must be admitted that whenever there has been understaffing in the institution, this has resulted in a situation which is similar in some aspects to overcrowding. We cannot deny that this institution has been understaffed except for that period of time between 6-16-58 and 12-31-59 when we had only a very minimum number of residents.

Graph Showing Growth of Number of Residents (Male, Female, and Total) Between 6-16-58 and 11-30-65, Brainerd State School and Hospital



3. Future Waiting List Considerations for this Institution.

As of December 1, 1965, the waiting list for Brainerd State School and Hospital included 125 names. Twenty-seven of these names might be temporarily deleted from this list, since they include the names of children of the age of four and under. With respect to the remainder of the age groups, we find that there are 26 on the waiting list who are five or six years of age, 51 who are between seven and sixteen years of age, 4 between seventeen and eighteen, 1 nineteen, and 16 who are between twenty-one and sixty-four years of age. However, this is by no means a complete picture of what might be called a waiting list for this institution. Since October 1, 1965 there has been a radical change in the route of admission to a state institution for the retarded in Minnesota. The change now leaves it up to the medical administration of the institution to determine admission or non-admission of possible new residents in a direct relationship between the institution and the county welfare boards. Formerly, the approach was by way of a third party, namely the Section on Mentally Deficient and Epileptic of the Minnesota Department of Public Welfare.

The waiting list cannot be as accurately enumerated nor predicted as in the past, since it is now possible for persons to be admitted to the institution who do not necessarily go through the older process of commitment by probate courts. This step may be bypassed entirely and county welfare departments, knowing their local situation, may now be able to stress the need for some emergency admission with possibly some greater effectiveness than in the past. This waiting list brake of the past may not be as effective in holding down the demand for an admission. It would appear that this new system may keep in some degree of hiding actual numbers of residents of our 28-county receiving district who may eventually need institutionalization here. We simply say, in this connection, that a clear picture of the so-called waiting list is not as apparent as it was in the past.

There are other significant developments in the field of the care of the mentally retarded in the State of Minnesota which will have a bearing on the need for increasing the facilities for institutionalization at this place. Besides the developments in public school special classes, an outstanding element of this kind is day center care which has been increasingly financed during the past two legislative sessions of our State Legislature. It is hoped that these developments will lead to a permanent slow-down of the development of the waiting list rather than a simple postponement of the day when institutionalization must occur.

We can no longer stand before a Legislative Building Commission and prove our case for more "patient beds" on the basis of statistics. Proof must come in terms of program needs rather than in talk of sheer numbers of waiting persons.

4. Receiving Area of Brainerd State School and Hospital Type of Area and Socio-Economic Status of Area Served.

The following map will indicate the names of the twenty-eight counties served by Brainerd State School and Hospital and the large northern area of the state which must be covered by its services. Generally speaking, this is the least thickly populated part of the State of Minnesota. It is noted for being, in its western part, coincident with the fertile Red River Valley, and in its other areas as being the outstanding summer resort section and heavily laked section of Minnesota. It is also the area of the famous Mesabi and Cuyuna Ranges which for decades have poured out their great wealth of iron ore. Its largest city is the City of Duluth with its great port on Lake Superior. St. Louis County, in which the City of Duluth is located, is the county of our heaviest population and a county which must contribute an outstanding number of residents of this institution.

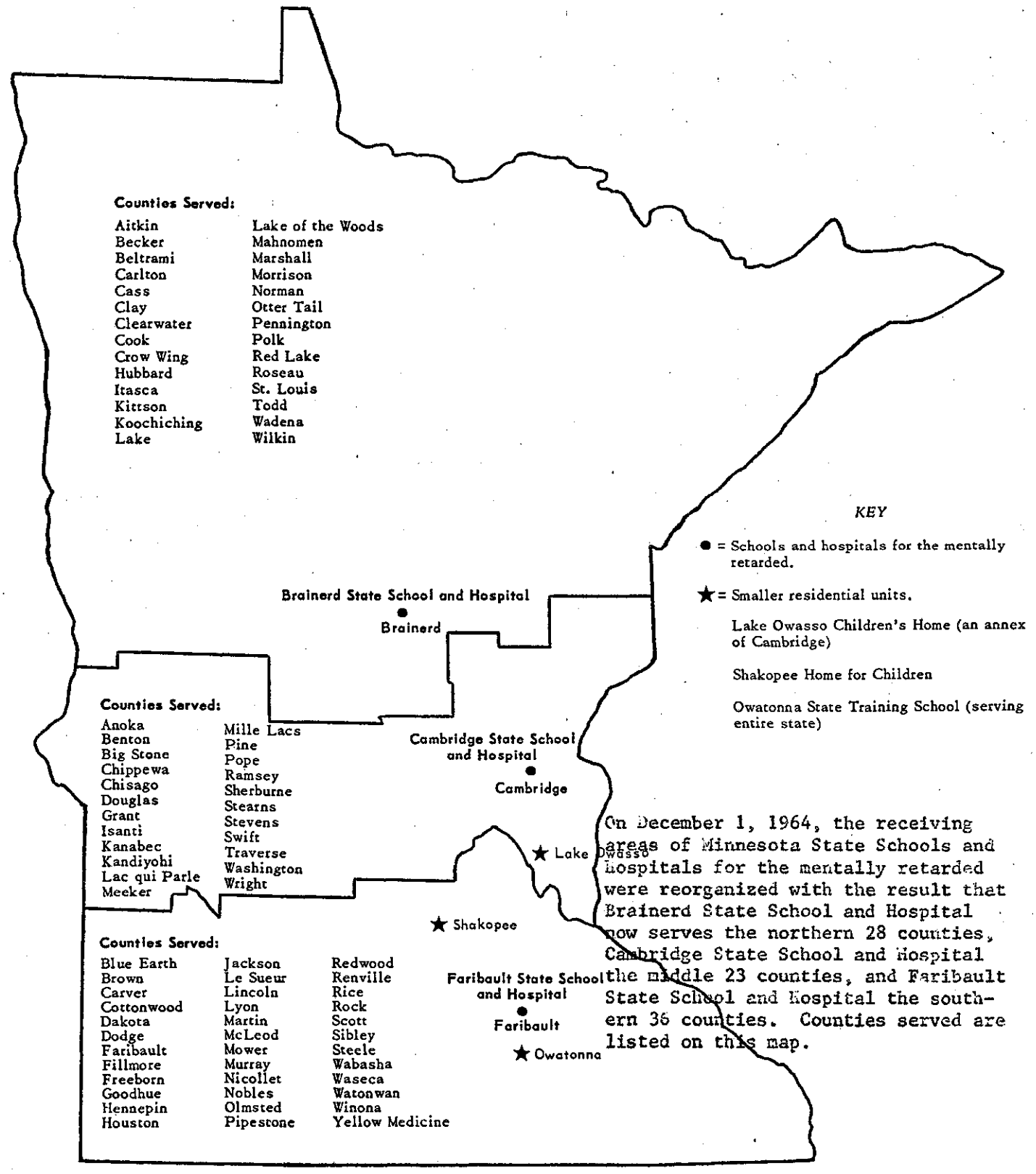
By and large, the receiving area of Brainerd State School and Hospital could not be said to be the area of highest average family income in the State of Minnesota. It is, nevertheless, that part of the state which has given Minnesota its name of being the Land of 10,000 Lakes.

The City of Brainerd is located on the main route of tourism in the State of Minnesota, and in Crow Wing County, of which Brainerd is the County Seat. There are 450 lakes in this county. Brainerd State School and Hospital is approximately one mile directly east of the City of Brainerd. It is 130 miles north of the Twin Cities and about 100 miles west of the City of Duluth.

MINNESOTA'S RECEIVING AREAS

STATE SCHOOLS AND HOSPITALS FOR THE MENTALLY RETARDED

DECEMBER 1, 1964



On December 1, 1964, the receiving areas of Minnesota State Schools and Hospitals for the mentally retarded were reorganized with the result that Brainerd State School and Hospital now serves the northern 28 counties, Cambridge State School and Hospital the middle 23 counties, and Faribault State School and Hospital the southern 36 counties. Counties served are listed on this map.

D. Picture of Brainerd State School and Hospital Personnel.

The listings of personnel which follow show all the personnel at this institution as of December 1, 1965. The listings also show the further anticipated development of personnel through June 30, 1966, which is the official end of our biennium.

The 1965 legislative session allotted 135 new jobs to this institution, of which 110 were in the direct patient care category. Since July 1, 1965, we have engaged in a successful attempt to recruit patient care personnel, and this has been our main stress. At the present time we have two Psychiatric Technician Trainee classes of 25 each in full operation. One class of 25 began on September 28, 1965, and the other on November 15, 1965. These are classes of 25 persons and are a pre-service rather than an in-service training type of program. Each class is in the program for a total of 800 hours, 235 hours of which might be regarded as vestibule training. They are enrolled in a five-month course with a newly organized curriculum, greatly enriched as compared with our past type of training program. The expense of teachers for the classes is, at the present time, being paid for under a MDTA project. All clinical instruction in connection with these programs is closely supervised by experienced psychiatric registered nurses. Visitations to other facilities involved in the care of the mentally retarded and/or of the mentally ill are a part of this course. A total of two weeks is spent at an institution for the mentally ill--in our case, use is made of Fergus Falls State Hospital. Other interesting and worthwhile care facilities in Minneapolis, St. Paul, Duluth and Fergus Falls are visited. There is also a period of training in a large nursing home in the City of Brainerd. Considerable planning and effort is made in connection with observation of the clinical activities of trainees on our wards.

It should be emphasized again that these are pre-service training and not in-service training arrangements. These people are under the schedules of the nursing education section and are not directly working for the nursing service of this institution. Upon completing their five-month course and passing their state examination, they will immediately be placed full time into the schedules of the nursing service.

In the meantime, while we await the completion of trainees in these courses, we have hired 35 Hospital Aides who, after a very brief period of orientation, are placed out on the wards during the day and afternoon shifts. It has been found that this kind of relatively untrained personnel is of tremendous service in the care of patients and they are used in many capacities. As trainees finish their courses, there will be a gradual diminution of use of the Hospital Aide as a temporary expedient, although it is our intent to keep them in employment as long as our financial arrangements can so afford. It may be said that we have kept up with and have passed the financial limitations upon us in the matter of

recruitment of patient care personnel to this point. However, we have an adjustable group in the form of the temporarily employed Hospital Aides, which we may increase or reduce in harmony with our financial resources.

We can cite as areas of critical personnel shortage the following:

1. Psychologists

2. Certain Special Teachers, especially in the areas of home economics, speech therapy, industrial arts, and physical education.

3. Further physical therapy personnel.

4. Occupational and Recreational Therapists.

We list the above for the reason that we have been allowed line items in our budgets to hire such personnel when they become available. We expect, from inquiries we have received, that by June of this year we may have been able to fill some of these shortages.

It may be worthwhile to note, as this application is further studied, that we are not asking for this type of short personnel in this project application. We shall ask for personnel that we are certain we can obtain.

We may conclude this part of our presentation by saying that there is in the State of Minnesota one of the strongest Associations for Retarded Children organizations in the whole nation. There are many branches of the ARC in seventy-five of our eighty-seven counties and their influence on the State Legislature is one of the very remarkable nuances in our recent political history. There is no question but that this great attention now being directed, nationwide and in this state, upon the problems of the mentally retarded will lead to further improvement of staffing of our institutions and an increasingly intelligent view regarding the necessity of good programs of training and treatment in our state institutions. We can say that we feel we are on the verge of a great development at Brainerd State School and Hos·ital which is in harmony with this increasing degree of attention to the problems of the retarded being given all over the nation and strongly so in the State of Minnesota.

Summary of Personnel, Brainerd State School and Hospital, as of December 1, 1965, with indication of Personnel to be Added Through June 30, 1966.

1. Patient Care, Treatment and Rehabilitation Areas

	Number of Positions filled On Dec. 1, 1965		Add'l Civil Serv. Positions to be filled by 6-30-67
	Civil Service	Part time Contractual	
a. Medical			
Medical Director		1	1
Dentist	1	2	
Clerical	1		
Physicians		12	1
b. Psychology			
Clinical Psychologist	1		
c. Chaplaincy			
Senior Chaplain (Catholic)	1		
*Junior Chaplain (Lutheran)	½	*Full time - ½ pd. by a Lutheran Synod	
d. Nursing Service			
Administrative R.N.s	2		
Nursing Education R.N.s	3		1
R.N.s (other)	13		4
Psychiatric Technicians II	23		
Psychiatric Technicians I	176		34
Remotivation Technician	1		
Clerk	1		
Hospital Aides	24		
e. Rehabilitation Therapies			
Director of Rehab. Therapies	1		
Supervisor	1		
Education:			
Special Teachers	4		4
Special School Counselor I	12		
Special School Counselor II	1		
Recreation	5		3
Handicraft	1		
Industrial Therapy	2		
Physical Therapist	1	1	2
f. Social Services			
Social Service Supervisor	1		
Hospital Social Worker	1		
Social Worker I	4		
Clerical	2		
g. Medical Records			
Medical Records Clerk	1		
Clerical	½		

Patient Care, Treatment and Rehabilitation Areas (Cont'd.)

	Number of Positions filled on Dec. 1, 1965		Add'l.Civil Serv. Positions to be filled by 6-30-67
	Civil Service	Part time Contractual	
h. Volunteer Services			
Volunteer Services Coord.	1		
Clerical	½		
i. Paramedical Services			
Laboratory	2		
X-ray		1	
EEG, EKG	1		
Pharmacy	1		
Barber	1		
Cosmetic Therapist	1		
	29½	15	51

2. General Services

a. Administrative		
Administrator	1	
Business Manager	1	
Personnel Officer	1	
Clerical	2	
b. Business Office		
Accountant I	1	
Account Clerk	1	
Stores Clerk III	1	
Bookkpg.Machine Clerk II	1	
Clerical	2	
Switchboard Operator	2	
Stores Clerk I	2	
c. Dietary		
Cook IV	1	
Cook III	3	
Baker II	1	
Baker I	1	
Meat Processor	1	
Truck Driver	2	
Cook II	4	
Cook I	2	
Food Service Supervisor	22	
d. Laundry		
Laundry Manager	1	
Laundry Supervisor II	1	1
Laundry Supervisor I	4	
Laundry Worker	7	
Custodial Worker	1	
Laborer I	1	

General Services (Cont'd.)

	Number of Positions filled on Dec. 1, 1965		Add'l. Civil Serv. Positions to be filled by 6-30-67
	Civil Service	Part time Contractual	
e. Engineering			
Plant Operations Supt.	1		
Asst. Chief Power Plt. Engr.	1		
Stationary Engineer	4		
Plumber	1		
Plant Maintenance Engr.	3		
Painter	1		
Electrician	2		
Mech. Stock Clerk I	1		
Truck Driver	1		
Groundsman I	1		
Laborer	2		
Carpenter	1		
f. Housekeeping			
Executive Housekeeper	1		
Housekeeper II	1		
Janitor	10		
Custodial Worker	16		1
g. Clothing			
Tailor Shop Foreman	1		
Seamstress	1		
Total General Services	116		2
Total Patient Care, Treatment, and Rehabilitation	292½	13	51
TOTAL EMPLOYEES	408½	13	53

E. <u>The Mission of Brainerd State School and Hospital as Shown by its Functions.</u>

1. Residents are to be afforded a care program for all their physical needs. This program of care is to be carried on under high standards of cleanliness and legal space requirements. Residents are to receive regular diets, as appetizingly prepared and served as possible, and special diets based on physicians' orders as needed. They are to be provided with properly fitted clothing suitable to their needs and in harmony with consideration for their dignity as human beings. They are to be given all needed medical and surgical care by competent physicians and around-the-clock care by trained psychiatric technicians who, in turn, are supervised by a corps of registered psychiatric nurses.

2. Care of residents must include care for the mentally retarded who are epileptic, who have mental illnesses superimposed on their conditions of mental retardation, who experience conditions of emotional disturbance, and who are victims of multiple physical handicaps.

3. Pervasive programs of treatment and training, both of a group and individualized nature, are to be provided the residents in this institution. Such programs, under a psychiatrically trained Medical Director, involve the fields of special education for the trainable and educable retarded, a wide range of recreational activities; the development of avocational interests, domestic training, guided work training, both within and outside the institution, religious and moral counseling, sensory training, and remotivational activities. These activities are aimed in the direction of improving the social adjustment of residents and attempting to develop whatever potential the resident may have for successfully returning to the community either permanently or for some time. Psychological testing and interpretation, case study and social service counseling with residents, parents and welfare agencies, resident councils, Chaplaincy services, and multi-disciplinary case conferences give specific guidance to treatment programs under the supervision of the Medical Director. This is a treatment and training program which must operate on many fronts.

4. Attempts to reestablish, especially through its social service department, lapsed familial relations of residents; to strengthen family interest in the patient in order to promote the morale of the resident.

5. Promotion of a wide scope of public knowledge concerning mental retardation and therewith development of a greater degree of sympathetic understanding and acceptance of the mentally retarded in the area served by the institution.

6. Development of voluntary services with the aim of continuous improvement of good relations between the institution and the local area and for the purpose of widening opportunities for contact between patients and a broader community.

7. The return of as many residents as possible to a resumption of a more normal life in the counties from which they came.

8. The relief of the great emotional strain and burden of taking care of certain of the mentally retarded in the home.

9. Protection of the retarded from exploitation.

10. Protection of the retarded from injuring themselves and others.

11. Lightening of the burden of communities which otherwise would find it necessary, but too often impossible, to develop their own facilities for dealing with this difficult social problem.

II. Functional Organization of Brainerd State School and Hospital for the Development of Patient Programs.

A. Past Programs at this Institution--Their Extent and Their Basic Lacks in Organization.

Past programs for our residents at this institution may be said to fall into two periods. The first period extended for some four years following June, 1958. This might be termed a period of loose organization of programs for residents. Two and one-half years following April 1, 1964 may be termed a formative period in the development of a true program organization for the institution. This latter period is characterized by the work of Dr. Harold P. Robb, Medical Director, and his leadership in the present program organization at Brainerd State School and Hospital.

The first four-year period of this institution was by no means lacking in services and somewhat loosely organized programs for our residents. With a large degree of independence, leadership in the creation of services and programs was assumed by the Patient Program Supervisor, the Industrial Therapist, the Handicraft Instructor, and four of our Special Teachers. There was a strong degree of unity in this organization provided through the Patient Program Supervisor, whose principal interest was in the field of recreation. It was felt necessary during this period that considerable freedom should be allowed enthusiastic supervisional personnel and professional personnel to develop their programs in the best way they possibly could. Areas of considerable freedom and creativity were therefore given to them.

At the same time, a large number of case conferences were held. In fact, the record indicates that during the first two years of the existence of Brainerd State School and Hospital, 152 case conferences were held. Leadership in the case conferences varied, although the conferences were multi-disciplinary. Case conference

was indeed a good name to give to these conferences, since they concerned our attempt to become well acquainted with the individual residents to the extent that we were able, and to try to suggest programs applicable to the needs of residents. There was as much follow-up on these case conference suggestions as could be derived from a rather sparse staffing ratio. The point must be made, however, that the case conference studied individual patients almost exclusively and that it did not try to cope with the overall problem of organization of programs. For this reason, it is admitted that, whereas a great proliferation of services came into existence during this period, the organization as it might apply to groupings of patients in program concentrations was hardly understood during this period.

It could be generally stated that a great game of "activity jackstraws" was played at this time. Many activities and interesting activities were begun, were carried on for some time, and then often died. There was not sufficient persistence and consistency and relatedness to groups of residents in many of these activities which were fine in themselves. Like comets, some of them blazed up for awhile and then died out. Nevertheless, it would be worthwhile to mention that during this period there were excellent handicraft classes, very considerable organization in industrial therapy activities, an exciting group of activities in recreational therapy; that there were four classes in special education, that there were special activities such as camping, Boy Scouts, resident councils and a resident paper; that there were outstanding recreational programs such as St. Patrick's Day resident talent programs, very large and complex Christmas activities, the building of a picnic area by the rehab people and residents, that there were bus trips to many interesting places, often far distant, that there was free attendance by residents at rodeos, horse shows and stock car racing, and that there were the beginnings of a remotivation program.

The participation in handicraft classes in which residents learned how to do large numbers of things was very extensive, particularly among female residents. This was due to the excellence of two handicraft instructors we have had. The industrial therapy program concerned itself with pre-industrial training programs set up on the wards for patients who could work only in wards, in work within the institution on a broad scale covering some 450 residents, and the strong beginnings of community participation in industrial therapy programs. That there must have been some success in the programs of this early four-year period, including the industrial therapy program, could hardly be denied since, during this period, 88 residents were successfully given trial placements. The number 88 is almost the equivalent of the number of patients who were in the hospital during the first year and a half of its existence. Twenty-six of the residents returned to their communities in successful work placements in which they earned at least a very good share of their necessary subsistence. None of these individuals have

ever been returned to Brainerd State School and Hospital, so we must assume that there was some success during this period of what may be termed "loose program organization".

To briefly continue with this: Recreational therapy perhaps assumed a very strong position during this first four-year period. There were limited ward activities; small group recreational sessions; large central activities, especially in the evening, covering such activities as social dancing, social dancing instruction, square dancing, movies, large social parties and community singing. There were special holiday events, celebrated with very considerable resident participation, events such as Halloween, Fourth of July carnivals, St. Patrick's Day talent shows. Sports were largely confined to softball, with considerable organization of league activities. A playground and picnic grounds were also made at this time by personnel from the rehabilitation department with the help of many of our residents. Special education classes were of the kindergarten variety, a more advanced group with certain elementary subjects akin to those taught in lower grades, and a more advanced series of classes in social training for older patients. Again, in this area, the teachers were allowed more than a little liberty in the development of their own teaching areas and plans.

In summarizing the characteristics of these first four years, we shall say that it was a period of loose organization, almost inevitable in the early history of an understaffed and beginning institution.

Since April 1, 1964, there has been a formative period in the direction of a true program organization which is described in the remarks that follow.

B. <u>New Concepts or Different Approaches to Resident Care Inherent In The Lino Lakes Program Outline</u>.

The new or different approaches to resident care inherent in the Lino Lakes program outline may be stated as follows:

1. That there should be the development of systematized, organized programs based on a detailed assessment of individual residents' needs. The first approach here listed might be defined more thoroughly through a statement of some of the following necessary elements in programs:

   a. All programs should be in harmony with attitudes in the direction of greater self-disciplined freedom for the resident.

   b. There should be a part in every broad program for every resident, as far as possible, and in this aspect the severely retarded patient, the bedfast patient, must be considered.

   c. Every program should have progression built into it.

d. There is a great necessity of setting up some system of measurement so that we may really know that a particular resident is being improved or not being improved by any part of his program.

2. That there should be a grouping of residents geographically within the hospital in accordance with such programs and that these residents so grouped should have considerably similar conditions which would create definable differences between the overall programs.

C. The Basic Work of the Two Interdisciplinary Teams Formed in November and December, 1964.

In November and December of 1964, two interdisciplinary teams were formed in the hospital. In composite effort, the teams developed a resident survey questionnaire which included ward technicians' estimate of the residents' needs, any known specific requests from the residents themselves, team estimates of the present condition of the resident, and the team's report of their opinion of the residents' needs.

The two teams then carried on a resident-by-resident review for a period of eight months. One team was responsible for a study of the male side and the other for the female side of the hospital. On the basis of this information gathered for all residents in the institution, and based on the definition of the six programs earlier mentioned, residents were eventually classified more objectively than in the past and with a more consistent underlying basis built on this eight-month study and experience of the teams. Final decisions with respect to the classification of the residents were made by the Medical Director. Decision with respect to the new locations in the wards to provide a better degree of related geographical location of residents in the program groups was also determined by the Medical Director.

D. The Physical Distribution of Residents.

In order to implement the development of programs it was found necessary to physically move 1108 residents in the month of August, 1965. About 200 were moved just between wards in the buildings where they lived; the remainder were actually transferred to other buildings. Since the move affected a number of departments besides the nursing service, the total movement was planned and supervised by the Civil Defense Committee, composed of three men in the institution. The complexity of this procedure is shown by the fact that Charge Technicians in each resident building had to possess a final list of all the residents who would eventually be in their building when the moving had been accomplished, a list of all residents to be transferred out of their building, and a daily list indicating the names of residents to be moved from the building. Timing of moves was important and a ruling was also made that there would be no movement on Saturdays and Sundays. Synchronization of the movement rather demanded that there be an equal exchange of residents between buildings on a

daily basis. There had to be a transfer of information about the resident to the staff of the new building. Medication information had to be rapidly placed in working order in the new building. Information regarding the diet of the resident had to be transferred with the resident, as well as all of his personal effects and clothing. Arrangements had to be made for a large scale re-marking of personally owned clothing. The problem of movement of residents who could not communicate their identification was important. Ruling had to be made regarding some policy with respect to discarding a resident's belongings at the time of the move, since often some of these articles seemed to have lack of value. Arrangements had to be made for transfer of medical records. Provision for clean beds and new linen had to be provided. A ruling had to be made regarding the transfer of residents who were on vacation at the time. Necessity to maintain an accurate daily census which would reflect the moves of all residents each day was important. There had to be the actual transfer of certain beds so that the right kind of beds would be coordinated with the movement of residents. The problem of transferring residents or leading them from one building to another without affecting the technician's service who had to remain in the building to receive other residents was thought of beforehand. Special moving help pools of volunteers and employees from other departments--particularly the rehab department--were set up. In order to facilitate the movement of residents, twenty-five emergency workers were hired for a 20-day period. These people were of great assistance. All moves daily were determined by two men from the Civil Defense Committee. It can be said that this very complex move was accomplished very smoothly in fourteen actual working days.

Naturally, these movements were accompanied by many an outcry of residents separated from friends, and by the feeling of some technicians that a great revolution was taking place. As time has progressed, however, these situations have quieted themselves; new adjustments have been made by both residents and technicians and we believe it is generally felt by employees that the basis is being laid for a progressive, well organized development of programs in the future.

A selling point has been made to the technicians to the effect that, on the basis of these moves and the work of treatment teams being developed, within a year and a half or two years their own jobs as psychiatric technicians will be at least twice as interesting to them as it is at the present time. Technicians now anticipate the development of programs. These programs are being developed through widespread participation of the resident care group of which they are a major part.

E. Organization for the Purpose of Program Planning and Implementation.

There is introduced at this point the organization of the treatment plan of Brainerd State School and Hospital which is now in existence. This plan may, in practice, have some minor operational changes but, by and large, it is the plan under which we operate. It was thought for some time that possibly we should

seek for program directors other than the heads of departments upon whom we rely at the present time. The progress of the treatment teams since this organization was set up in August, 1965 appears to have reduced the need for different program directors. Our program directors, as presently designated, have stated their feeling of the great worthwhileness of their work with the treatment teams to the point where they would like to continue what they are doing. There has been some small objection brought up against this view, since, as department heads, these people have other administrative duties that are possibly heavy enough and, second, there is the peculiar situation in which the program directors also sit in an overall group of supervisional authority, namely the Treatment Planning Team. Despite these possible objections, it is generally felt that the organization as set up in the plan herein works quite well at this institution.

In summary of this, it is plain that the organization of treatment is based on the unit system at this institution. This form of treatment organization is very closely akin to the unit organization which is prevalent in the State of Minnesota in the institutions for the mentally ill.

ORGANIZATION OF THE TREATMENT PLAN

AT

BRAINERD STATE SCHOOL & HOSPITAL

This is an attempt to divide a 1400 bedded hospital into four smaller relatively autonomous units. Each unit deals with patient residents who have a predominant group of needs in common. Each unit carries out a different program and is situated in a different part of the campus as follows:

Program 1 & 4

CHILD AND ADULT ACTIVATION PROGRAM in Buildings 1-B, 19C & D, 20B & D, and 21B & D. This deals with the bedfast and severely physically handicapped child and adult. There are 231 patients in these programs.

Programs 2 & 3

PROGRAM 2 - CHILD DEVELOPMENT PROGRAM dealing with ambulant children from age 3 to Puberty.
PROGRAM 3 - TEENAGE PROGRAM dealing with young persons from Puberty to age 16.

Both these Programs are directed by the same person and are housed in Buildings 6 and 8. There are 162 patients in these programs.

Program 5

ADULT MOTIVATION PROGRAM. More retarded adults from the age of 16 onwards. These are found in Buildings 7, 9, 10, 17, and 19B, 20C, and 21C. (The last three wards should all be in one building; but are placed as they are to relieve the task of Nursing Service in Buildings 19, 20, and 21 who would otherwise have three wards of Bedfast or Wheelchair patients to look after. This should be changed with the addition of more staff.) There are 534 patients in this program.

Program 6

ADULT SOCIAL SKILLS PROGRAM. Ambulant residents from the age of 16 and upwards. Some could work and live outside with supervision. Others work well inside, but are not ready to live on the outside. Others have character disorders. They are housed in Buildings 5, 22, 1AA, 1C and 1D. There are 452 patients in this program.

Four Teams and four Program Directors have been chosen to manage these programs. Three of these Directors are Service Chiefs who are filling in until permanent Directors can be obtained. With an increased number of staff and an increased public acceptance, it would be hoped in future phases of the organization that the Nursing Service (RN's) could be involved on a program basis.

With the exception of the Medical Service and the Nursing Service, the Teams chosen are as follows:

	Team 1-4		Team 2-3		Team 5		Team 6	
	Needed	Current	Needed	Current	Needed	Current	Needed	Current
Program Director	≠	RN with Rehab Nursing Experience	≠	Teacher Ed. Psych. Exp. & Trn. Child Development	≠	Research Psychologist Exp. in applied Tech. of Conditioning & Training	≠	Social Worker Exp. in Group Skill
Temporary Program Director	≠	Physical Therapist	≠	Mr. Bader	≠	Dr. Willenson	≠	Mr. Steen
RN Supervisor	≠		≠		≠		≠	
RN Building	≠		≠		≠		≠	
Tech 2, AM-PM	≠		≠		≠		≠	
Tech I	≠		≠	(Possible School Counselor)	≠		≠	
M.D.	≠		≠		≠		≠	
Orthopedic Consultant	≠		≠		≠		≠	
Physiatric Consultant	≠							
Physical Therapy	≠	Mrs. Skarloken	≠		≠		≠	
Teachers-Trainable			≠	Mrs. Frank				
Teachers-Educable			≠	Mrs. Bentler			≠	Mr. Stave
Teacher-Home Ec			≠				≠	
Teacher-Ind. Arts			≠				≠	
Speech Therapist			≠		≠		≠	
Occ. Therapist			≠		≠		≠	
Arts & Crafts					≠		≠	Mrs. Yantes
Recreation	≠	Mrs. Skarloken	≠	Mrs.K.Smith	≠	Mrs.Yeager Rollie Smith	≠	Mr.McGerr Mr.Endres
Music	≠		≠		≠	Mrs. Schmid	≠	
Inst. Work Placement					≠	Mr. Brixius	≠	Mr. Brixius
Work Training							≠	Mr. Maher
Psychology	≠		≠		≠		≠	
Social Service	≠	Miss Turcotte	≠	Mr. Torrence	≠	Mr. Selover Mr. Crowley	≠	One Social Worker **
Volunteers	≠		≠		≠		≠	
Remotivation	≠		≠		≠		≠	
Religion	≠	Rev.Krueger	≠	Fr.Theisen	≠	Fr.Theisen	≠	Rev.Krueger

* ≠ - Essential Service
≠ - Desired Service

** One Social Worker will participate in each meeting when the meeting is held in his building. (Rowe, Selover, Turcotte, or Torrence.)

Treatment Planning Team

The Treatment Planning Team is responsible for the total treatment efforts of the Hospital under the direction of the Medical Director, or in his absence, under the direction of the Chief Psychologist, Dr. Willenson, Ph.D. The Treatment Planning Team is responsible for:

1) Developing the Hospital Philosophy.
2) Creating therapeutic atmosphere.
3) Shaping hospital policies and procedures to effect these two ends.
4) Direction of the Program Directors.
5) Determining the priorities of Staff and of Programs.
6) Approving the recommendations of the Discharge Clinic regarding patients leaving the hospital.

The persons involved in the Treatment Planning Team are:

Medical Director
Chief of Social Service
Chief of Rehabilitation Services
Chief of Nursing Service
The Administrator
Chief Psychologist

and if possible,

The Chief of Staff.

Program Director

The Program Directors are responsible for:

1) Developing programs for their particular group.
2) Determining priorities within their group.
3) Interprogram transfers after consultation with the appropriate Director of the other Team.
4) Team development.
5) Conveying to the Heads of Departments their requirements for the programs in their Team.

Teams

The Teams are responsible for:

1) Evaluating the needs of residents.
2) Developing a therapeutic atmosphere in the buildings.
3) Recommendation for program placement such as work, education, recreation, etc.
4) Movement within the buildings.
5) Vacations, ground privileges, downtown privileges.
6) Limit setting. They may restrict the resident when appropriate to the building for up to one week.
7) Seclusion - in an emergency, for example, overnight. Permission for seclusion should be obtained from the Program Director. Otherwise needs a medical order.
8) Drugs, medications, and treatments should be ordered from the Physician caring for these patients.

At the discretion of the Program Directors, the Teams can be divided into sub-teams to combine with the Building Staff. All employees who work in a building should be considered as eligible for the building team, e.g., Custodial Workers, Food Service Supervisors, Janitors, and they should be encouraged to attend.

The other Committees that are involved in the treatment planning are:

1) Admissions and Discharges Clinic consisting of the

Chief Psychologist
Chief of Social Service
Assistant Director of Nurses
Chief of Rehabilitation

They are responsible for determining admissions, accepting the discharge and trial placement recommendations from the Teams and considering these and considering transfers between hospitals. They are answerable to the Treatment Planning Team.

2) Inservice Training Committee consisting of

Nursing Service
Nursing Education
Chief Psychologist
Chief of Rehabilitation

3) Humane Practices Committee which is under the leadership of

John Maher, Industrial Therapist, and
Mrs. Yenish, RN III

and is made up largely of Tech II's. They, at present, meet weekly and are answerable to the Treatment Planning Team to whom they should report.

Physicians are presently assigned to each team and are available to these teams at such times as their advice or consultation is requested.

Nursing Organization

1B 1A and the Doctors' Clinics plus other duties such as immunications	Mrs. Johnson
Bldg 22, 17, 20, 21, 19	Mrs. Beaulieu, Mrs. Molestad. Mrs. Christensen (RN with Kenny Rehabilitation Nursing Course) will overlook Bldg 20, 21, and 19.
Bldg 5, 6, 8, 7, 9, 10	Mrs. Yenish and Mrs. Froelich with Mrs. Froelich concentrating on Bldgs 6 and 8.

Nursing Organization (Continued)

For the afternoon shift, these RN's report to two RN's and for the night shift, the two RN's report to one; so that the total RN coverage is four RN's in the morning shift, two in the afternoon shift, and one RN at night.

Medical Organization

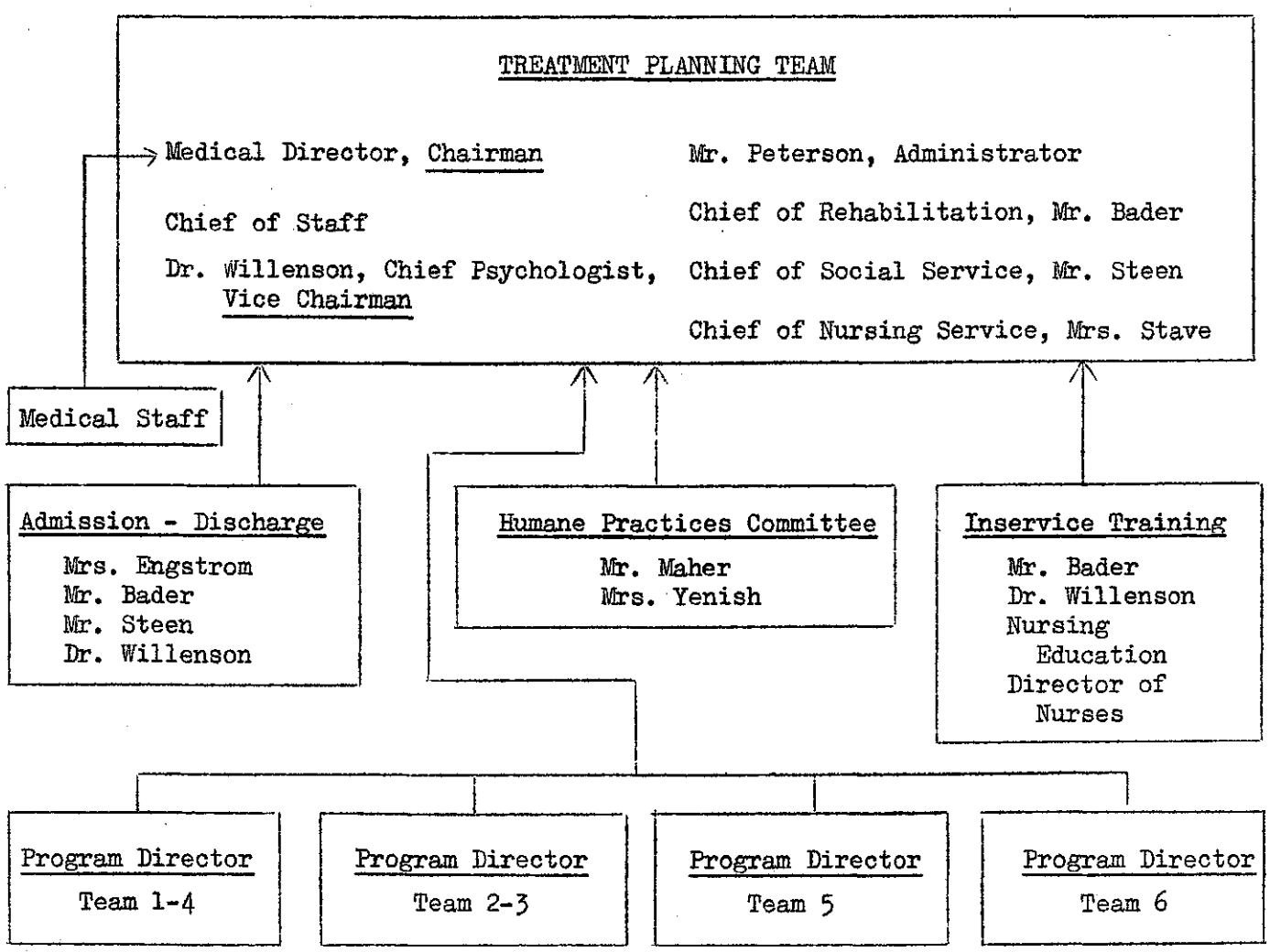
One Doctor attends the hospital and the central Out-patient Clinic in the Main Building and the male emergencies, and afterwards goes to the female side to deal with female medical problems. The next day, he does the hospital and central Out-patient Clinic and female emergencies and then goes to the male patients.

On Saturdays, the Doctor sees all the patients in the Main Building.

For the other Doctors' Clinics, Mrs. Johnson, according to Mrs. Stave, would do most of the arranging. Mrs. Molestad will accompany Dr. O'Leary. The afternoon RN on the appropriate side will accompany Dr. Mulligan.

A Psychiatric Clinic is held once a week. Dr. Robb visits buildings on both the female and male sides as well as Bldg 1.

* * * * * * * * * *


TREATMENT PLANNING TEAM
Medical Director, Chairman
Chief of Staff
Dr. Willenson, Chief Psychologist, Vice Chairman
Mr. Peterson, Administrator
Chief of Rehabilitation, Mr. Bader
Chief of Social Service, Mr. Steen
Chief of Nursing Service, Mrs. Stave
Medical Staff
Admission - Discharge
Mrs. Engstrom
Mr. Bader
Mr. Steen
Dr. Willenson
Humane Practices Committee
Mr. Maher
Mrs. Yenish
Inservice Training
Mr. Bader
Dr. Willenson
Nursing Education
Director of Nurses
Program Director
Team 1-4
Program Director
Team 2-3
Program Director
Team 5
Program Director
Team 6

HPR/rm

F. Therapeutic Aims as Related to the Four Basic Programs.

Therapeutic aims as related to the four basic programs of this institution may be stated as follows:

1. To promote more effective return to the community of those of our residents for whom some opportunity for return may be developed.

In this aspect it must be remembered that there are a number of resources used for placement in communities. Among these may be enumerated the work home situation wherein the resident is given a home and does considerable work in this supervised home. Residents may be returned to the parental home, placed in nursing homes, rest homes, boarding homes, foster homes. In rarer instances, they may come to live quite independent lives, earning much if not all of their livelihood. It should be one of the aims of the programs to consider the kind of placement that might be available for residents and to try to develop those changes in habit and attitude which may enable the resident to fit better into whatever kind of placement may eventually be arranged for him.

2. To develop all residents as closely as possible to the potential limits that they may have for such improvement.

Specifically, this would unfold largely in the development of self-help or self-care skills, social skills, motor skills or body usage experiences, basic knowledge or academic skills (language and number usage), expressive activities (arts, crafts, music, dramatic play), and vocational skills.

3. Special attention to residents with long standing speech and hearing defects, conditions of cerebral palsy, psychotic conditions or conditions of emotional disturbance.

The last of these listed conditions is considered to be quite prevalent among the institutionalized mentally retarded.

4. To alleviate the condition which may be called over-institutionalization of a patient with its resultant overdependent attitude.

5. To fight, on all fronts, those elements in the total institutional environment of the resident which are dehumanizing. The number of such elements and conditions in even the best of institutions is almost staggering to contemplate. We would regard that any treatment program must maintain a very basic and persistently intelligent war on such elements within the environment of the resident.

G. Topics Now Being Studied By the Four Treatment Teams:

Since our programs for patients are now in the beginnings of development, we consider that it would be most useful merely to list the kinds of questions being studied by each treatment team. It will come to be seen from the lists that different problem emphases are to be found in each of the broad program areas. These in turn reflect the organization of residents within the institution on the basis of certain similarities. To many of the problems listed the teams have made answer. Some of these answers have lead to the real beginnings of definite overall programs for the groupings; other answers meet the individual problems of certain patients.

It should be seen from the following lists that beginnings are being made; that some structural stones in the foundations of future programs are becoming discernible. It probably will become apparent that one of the four programs lies in rather more difficult areas than do the others. It is this program we regard as needing most plainly the help of the Hospital Improvement grant. The listings of topics for each of the four teams follows below:

1. Team Topics - Programs 1 and 4: Child and Adult Activation Program - for the bedfast and severely physically handicapped child and adult. (124 males, 107 females, 231 total residents)

Clothing required for new patients
Need for volunteers on a one-to-one basis
Suggestions re patients to be transferred out, especially to nursing homes.
Suggestion for medical record improvement, especially records with respect to blood pressure.
Referral of specific patients for specific services.
Self-Care Training
How to "stimulate" such patients.
Plans for building or supplying of adaptive equipment.
Transfer of patients to other wards in the same program.
Transfer of patients to other programs
Request for teaching services on the ward or at the bedside.
The problem of the transportation of patients to physical therapy or to the dentist.
The policy with respect of a family furnished TV for one patient
Glasses for certain patients
Proposal to build storage drawers for certain patients
The extension of physical therapy services and the services of rehabilitative nursing.
Sensory training.

2. Team Topics - Programs 2 and 3: Child Development Program dealing with ambulant children from age 3 to puberty; Teenage Program dealing with young persons from puberty to age 16. (105 males; 57 females; 162 total residents).

Hair styling with volunteer help
Rearrangement of patients
Evaluation of patients with respect to more formal school enrollment

Staffing needs, especially in the Teenage Building.
Use of recreation staff to alleviate lack of ward staffing.
Policy re smoking by children under 18.
Ventilation problems
Community type placements - rather than nursing home placements
The problem as to whether the patient "should be viewed" or interviewed at the time of team discussion.
Team objectives as related to the patient group as a whole and as related to the individual patient.
Use of The Quiet Ward.
Shigella quarantine problems
Need for one locked ward
Confinement as a poor solution.
Recommendations for medical evaluations.
Need for assignment of certain more advanced patients to assist with individual problem patients.
Visiting privileges in local homes.
Suggestion that some of our outside playground equipment be installed in dayrooms.
Offer of help from local professional beauticians.
Study of daily patterns followed by patients.
Attention span.
Study of self-wounding habits and possible solutions.
Staggered feeding schedules to relieve patient feeding problem.
The saturation technique (buying a large number of the same kind of toy; patient using and possibly breaking a number, until right use and care is learned)
Request for nursery rhyme records.
Helmets for nose pickers.
Use of the tunnels.
Escort policies.
Volunteer help for writing home at Christmas.

3. <u>Team Topics - Program 5: Adult Motivation Program</u> - dealing with ambulatory residents with intellectual range from "below test limits" to the low 50's. (218 males, 316 females, 534 total residents).

Seclusion regulations.
Intra-program transfers.
The wide variety of conditions - and resultant problems - of this program group.
Toilet Training.
Training in dressing and undressing.
Food grabbing.
Need for training of staff in the concepts of operant conditioning.
Developing interest of patients in simple occupations.
Inventory of patient conditions.
The token payment plan.
A system of progress evaluation in a program of meaningful evaluation covering activities in the following categories: Passive, Simple Motor Skills, Advanced Motor Skills, Self Expression, and Social Participation.
Tunnel policies.
Broadening of referral form.
Humane Practices Memorandum re use of patient funds.

4. Team Topics - Program 6: Adult Social Skills Program for ambulant residents from the age of 16 and upwards who have better abilities than patients in Program 5. (243 males, 209 females, 452 total residents).

Shortage of tobacco
The card merit system with difference in method to be tried experimentally in two large patient areas.
Recommendations with respect to programs for individual residents.
Preparing patients for use of their leisure time while on trial placement.
Needs for certain equipment related to the program.
Pass cards as related to privileges and merit system.
Trial placement recommendations.
Special bus trips.
Suggestions from patient council.
Tunnel problems.
Choice of follow-up team person.
Referrals to teachers.
The independent living unit.
Temporary training transfers to certain other state institutions.
Behavioral problems.
Problem of buying and selling patient-made items.

In summary, we feel that perhaps the most difficult program is Program 5. We also feel that, despite great difficulties within all of these programs, progress is being made toward the laying of overall program foundations for each of the program groups. Finally, these are but beginnings in this newly formative period.

III Hospital Improvement Project Grant Application

A. The Intention of This Proposal

It is the intention of this proposal to show the need for a truly additive program, different from any we now have at Brainerd State School and Hospital, directed toward behavioral modification of the adult severely and profoundly retarded through habit training. We intend to show the great need for strengthening of our training program in what is known as the present Program #5, named, in this institution, the Adult Motivation Program. It is our intent to confine this application for a Hospital Improvement Project Grant to a program for adult residents. The grant would be restricted for use among the four buildings which exclusively house Program #5 residents.

This group represents a massive human problem in habit training which requires a specially oriented additional staff. It is the most neglected and the largest patient program group in Brainerd State School and Hospital.

B. Description of Program #5 Residents

1. General Definition of Residents in the Adult Motivation Program

Our Program #5, named the Adult Motivation Program, as of December 1, 1965, covered 534 residents, or 38.8% of the total resident population. 316 of the residents were males and 218, females.

The Adult Motivation Program is for ambulatory late adolescent, adult and aged patients. The intellectual range of patients in this group is from "not testable" to the low 50's. Many of these residents show evidences of congenital cerebral underdevelopment and external congenital anomalies. Many are characteristically passive, withdrawn, and manifest peculiarities of behavior such as rocking and making odd noises. Many are hyperactive and many require total nursing care because of lack of training. Given adequate stimulation, opportunity, and training, a large number are able to enjoy occupational therapy and recreational activities.

The group also includes quite a number who function at very simple work in the institution but who still need further training in the overall program of the #5 group.

2. Ages of Residents

The following listing shows the ages of all residents who have been selected to be in the Adult Motivation Program, as of December 1, 1965. It may be of interest to note that the median age for the 316 male residents is between 33 and 34 years; the median age for the 218 female residents is 37. The overall median age for the total population of 534 residents in this program is between 34 and 35 years. As a general rule, it may be said that the program begins with residents who are 16 years of age and reaches into the middle 60's. Three-fourths of the male patients fall in the age range from 16 to 46. Three fourths of the female patients fall between the ages of 16 and 53. The tabulation of residents by age follows:

Program #5

Age	Male	Female	Total
11	1		1
14	2		2
16	8	5	13
17	8	7	15
18	14	6	20
19	11	8	19
20	8	8	16
21	15	2	17
22	8	11	19
23	8	4	12
24	7	5	12
25	5	5	10
26	13	4	17
27	12	6	18
28	5	6	11
29	7	5	12
30	7	4	11
31	7	3	10
32	10	3	13
33	2	3	5
34	8	3	11
35	8	7	15
36	4	2	6
37	6	2	8
38	2	7	9
39	4	7	11
40	11	4	15
41	7	3	10
42	6	4	10
43	10	5	15
44	7	3	10
45	9	3	12
46	6	7	13
47	8	6	14
48	6	3	9
49	3	2	5
50	5	4	9
51	5	5	10
52	2	4	6
53	3	5	8
54	5	4	9
55	5	3	8
56	3	4	7
57	3	2	5
58	5	2	7
59	4	4	8
60	1	2	3
61	5	4	9
62	1	3	4
63	3		3
64	1	2	3
65		4	4
66		2	2
67	1		1
70	1	1	2
Totals	316	218	534

3. Summary of Surveyed Characteristics of Residents, Program #5

Under the direction of our clinical psychologist, David Willenson, Ph.D., there was a recent survey of 515 patients in Program #5 with the purpose of evaluating their need for training and therapy. This survey was based upon a listing of items prepared by Dr. Willenson, a copy of which is included as Addendum #1 of this application. Evaluations were made in the case of 515 patients by the Psychiatric Technicians II in charge of the buildings with the assistance of advice from Psychiatric Technicians I who, in some cases, might have closer knowledge of the resident.

A summary of the findings of the survey was made, which may be summarized as follows:

	No.	Percent
Self-Care		
Must be bathed	168	32.6%
Must be dressed	128	14.8%
Toilet Habits:		
Incontinent	52	10.1%
Partially Trained	65	12.6%
Total	117	22.7%
Must be fed	29	5.6%
Medical-Physical Disabilities		
Diabetic	6	1.2%
Epileptic	85	16.5%
Cardiac	5	1.0%
Blind	24	4.7%
Deaf	10	1.9%
Emotional Disorders		
Psychotic-like symptoms	144	28.0%
Hyperactive	139	27.0%
Passive	112	21.8%
Unpredictable	218	42.3%
Appears confused	94	18.2%
Assaultive	40	7.8%
Self-Abusive	42	8.2%
Uncooperative	168	32.6%

A casual inspection of the data indicated that the majority of problems in self care and emotional disorders involve between 100 and 200 patients. An important finding in the survey was that there existed a considerable overlap among these two categories to the extent that a patient who was incontinent had often not learned any of the other self care skills and was, as well, showing uncooperative behavior. The inter-relatedness of treatment problems and the scope of needed habit training was easily noted as a result of the survey

C. Summary of Living-In Locations, with Characteristics of Residents and Staffing Ratios

The four resident buildings which provide the living quarters solely for residents in Program #5 were built as a result of appropriations by the Minnesota State Legislature in 1959 and 1961. The approximate cost of each building with equipment was $750,000. All four buildings are identical in structure and hold three separate wards of 36 beds each. Total residents in the four buildings are 426.

These buildings are built in the form of a cross and are one-story buildings with basements. In addition to the three wards which form the cross structure of the building, there is a fourth extension, a general service extension. This area, on the first floor, houses the lobby, the clinic, a doctors' office, attendants' locker rooms with showers, a general purpose room for educational purposes and a 60-place dining room with cafeteria and electric dishwashing facilities, a delivery area, a soiled linen sorting area and a large clean linen storage room.

Each of the three patient wards has a separate dayroom, attendants' or nursing station, clothing room, utility room, washroom, toilet area and bathroom. There is space for 36 beds in each ward and semi-privacy is afforded by part wall elevations which divide the beds in groups of six.

Two isolation rooms are provided on the first floor of these buildings. The basement contains a large, well lighted recreation room with adjacent recreation storage room and proper toilet facilities. The recreation room is approachable by two staircases, an oil-hydraulic passenger elevator, and is also accessible through the tunnel system.

All food is centrally prepared at this institution and is trucked overland in aer-void and other heat preserving containers. When the food is delivered to the patient area, it is immediately placed in the warming sections of the patient cafeteria. All cafeterias are staffed with a Food Service Supervisor for the morning and noon meals. College students employed under the Economic Opportunity Act aid the nursing service in handling the evening meals for patients.

An outstanding feature of the building structures is that each of the three living wards is distinctly separate from the others and in no case is there any violation of the standards of the Minnesota State Department of Health with respect to area of either bed space or dayroom space. There is no overcrowding from the point of view of space at this institution. The effect of the separation of the wards in each of these buildings is almost demanding of certain kinds of staffing ratios which, despite the innate demands of the structure, have not been fully met by the State Legislature.

Reference may be made to Page 9 of this application, which shows the location of the buildings by number.

Building #7 houses 106 male ambulant residents of age range 16 to 63. Seventy-one of these patients are not working. The building has a full staff of 11 Psychiatric Technicians, assigned three to morning, two to

afternoon and two to night duty. This makes a daily staff of seven, plus four relief people.

Building #9 houses 108 male ambulant residents, age range from 16 to 64. Seventy-two are not employable, with one-half of these hyperactive. There is a staff of 12 which works 3-3-2- on the three shifts.

Building #10 contains 106 male ambulant residents in the age range from 17 to 67. One of the wards has workers, but there are 70 non-working residents, 34 of whom are hyperactive, in the building. There is a staff of 11, which provides staffing as far as possible on a 3-3-2 shift day.

Building #17 contains 106 female ambulant residents, all non-working, in the age range of 16 to 51. Many of these are hyperactive. There is a staff of 12 assigned on a 3-3-2 shift basis.

It is plain from observing the staffing ratios in each of these buildings that always on the night shift there are only two aides available for three separate wards, and in the afternoon shift there are sometimes only two aides to cover three wards.

Fortunately, cleaning duties are quite well taken care of by Janitors and Custodial Workers working under a unit system of organization through the housekeeping department, so the Psychiatric Technicians are not encumbered very much with that kind of work. As mentioned above, the food service, with its Food Service Supervisors and the help of college students, alleviates to some extent the burden of feeding problem during the day, but the nursing service cannot escape considerable participation in this problem. Thus far, we do not have evidence that the rehabilitation staff people play a strong role in the activation program for this kind of patient.

The population in the four buildings briefly described above are the residents who would become involved in the project under description in connection with this Hospital Improvement Grant application.

D. Staffing Shortages

1. Staffing ratios compared with AAMD "Standards for State Residential Institutions for the Mentally Retarded"

Under present circumstances, residential care personnel, called Psychiatric Technicians, have an average ratio to patients of 1:35.5 for the morning shift, 1:44.3 for the afternoon shift, and 1:53.2 for the evening shift in the four buildings. Comparing these ratios with the manual "Standards for State Residential Institutions for the Mentally Retarded", January, 1964, Vol. 68, No. 4, American Journal of Mental Deficiency, P. 72, the ratios advocated for the particular groups which most closely fit our Program #5 residents are 1:10 for the first shift, 1:15 for the second shift, and either 1:15 or 1:30 for the third shift. Considering every dormitory building as operating at maximum patient capacity, the recommended personnel crew should be 11 on the first shift, 7 on the second shift, and at least 4 on the third shift; for a total of 22 Psychiatric Technicians for the 24-hour

day and a full staff of 35 per building to take care of relief personnel. Even though this ratio is considered conservative by our Clinical Psychologist, the number of Psychiatric Technicians now employed is approximately one-third of these standard figures. It is almost axiomatic that such a limited staff would be overburdened simply in providing minimal custodial care. As is frequently the case, the absence of a Technician from a building leaves a ward untended except perhaps for an industrially employed resident. Such absence, especially when patients must be accompanied by a Technician for medical examination and treatment, may often be for over an hour.

Standards set forth by the American Association of Mental Deficiency with respect to staffing in care of this kind of resident are certainly not to be taken lightly and point up again that a worthwhile habit training program can hardly be built up without additional staffing.

2. Shortcomings of Program #5 Ward Care as Revealed by a Check of Time Spent by Psychiatric Technicians During a Typical Work Week.

As a further check, our Technicians in these four buildings were requested to estimate the time spent in various duties during a typical work week. These reports were averaged and the hours converted into percent of work time. The results placed the greatest time in tasks of custodial care, the next greatest in clerical-administrative duties, the third greatest in routine preparation and maintenance, and the last in patient activation, training and individual attention. The sum of these categories credits Technicians with 8.46%, or approximately 3 hours and 23 minutes of a 40-hour week in attention to other than the patients' physical needs. Further inquiry indicated that no special training of any kind is provided on the wards that could be regarded as very significant. Whenever time permits, groups as large as 70 are escorted to the basement recreation area, and are engaged in exercise and games for about an hour. Such activity may occur a maximum of three times weekly, sometimes not at all. In spring and summer there is hardly enough help for escorted group walks around the campus.

The form used in determining the percentage of time spent by Technicians in varieties of patient care is provided in Addendum #2 of this application. The overall average percentages are included in the addendum.

3. Conclusion with Respect to Staffing Shortage

We feel that there is hardly a possible question but that the staffing ratio afforded Program #5 patients at this institution are far too low to provide hardly anything but a custodial program, and that hardly more than a minimal custodial program. This basic and almost tragic staffing condition can be further underlined by the indisputable fact that Brainerd State School and Hospital, chiefly because it is the youngest of the ten large state mental institutions in Minnesota, has the sparsest overall staffing ratio of any of the state institutions. As of

January, 1965, the best institutional ratio of our ten mental institutions in Minnesota is one employee to 1.69 patients. The next best is that of one employee to 1.84 patients. The overall ratio at our institution is one to 2.9 patients and we must repeat that this is the most sparse ratio of employees to patients in any of the ten institutions of the state. This includes the other two institutions at Cambridge and Faribault which are institutions for the mentally retarded and have more residents. This condition prevails despite the fact that the 1965 Legislature gave us 135 new positions. We are still about 46 employees short of this goal and we cannot expect to have them here until about a year from now.

We must repeat that sparse means a scanty quantity, thinly distributed over a wide area, and this is very true of the staffing we can afford for Program #5 patients. This fact of sparse overall staffing as compared with the other state institutions, underlines our previous observations regarding specific lacks of a good staffing ratio in our whole Program #5 organization.

We have the treatment team organization here. We think we have a rather clear idea as to what kind of programs these patients should have. But staffing ratios indicate that plans and even understanding are not sufficient. We need the help that we are asking for in this application, and we acknowledge that we need it very much, indeed.

E. The Project Plan

1. Nature of the Project

On basis of the above findings, it is proposed that one dormitory ward with a maximum capacity of 36 residents be designated as the Intensive Training Unit. Its purpose shall be that of attempting to modify the present behavior of severely and profoundly retarded adults through habit training by the techniques of constant attention, consistent practice, and reward for the desired behavior. This plan intends to adapt the principles of operant conditioning to the type of training given whenever feasible, or to use other learning principles if shown to be effective. Throughout recent literature on the effects of operant conditioning with respect to the retarded, the group consistently selected for these experiments have been children. Even though in most residential institutions for the mentally retarded, the non-trained adult is the largest group, to the present there has been no research to assess the effect of intensive training on them that is known to us. It is acknowledged that children are more readily adaptable, and that the establishment of self-care habits at an early age is most desired. The probabilities are strong that attempts at training severely retarded adults will require a longer time interval under more rigorous conditions. It is presumed that older patients will have a more intensive and protracted resistance to attempts at behavior modification than children. This may be manifested in temper tantrums, aggression, or sullenness, until they eventually become aware that desired responses are rewarded. It is also presumed that

training conditions will have to be maintained for a longer interval of time before these habits become firmly fixed. A primary interest of this program will be to determine to what degree the severely mentally retarded adult will respond to a full program of training, how long it will take, and whether regression will occur when the individual is placed in a different environment.

The objective of the project is to provide a program of total training with the individuals selected. The rationale for this approach is the interrelatedness of the many self care skills and behaviors in a child which receive concurrent attention from a parent in the maturation process. The acquisition of certain minimal skill in dressing and undressing must precede or accompany toilet training, as there is a partial dependency of one upon the other. Unless dressing skills are present, toileting cannot become an independent act. Bathing skills also are part of the establishment of a set of cleanliness habits which involve combing hair, brushing teeth, washing hands before meals, as the most important. Training in the use of tableware is associated with cleanliness and is a regular part of feeding children. As the child develops, undesirable acts of behavior are inhibited and socially desirable acts are approved. Refinement of motor skills is developed through the use of manipulative toys and games. The training here contributes to increased dexterity in the habit training mentioned above. In addition, but by no means less important, are the concomitant benefits of a directed physical and emotional release of energy, an increased attention span, and awareness of social interaction. Accepting this as the paradigm of average childhood training, it then appears that any project which emphasizes only the improvement of a single habit or skill without equal attention to others has lost through shortsightedness the reciprocal reinforcement it may have gained by attention to a broader program of intensive training.

2. Basic Staffing Required

Published research in the area of habit training have had patient-employee ratios that range from 1:1 to 1:11. The "success" claimed by the study using the former ratio was substantial, while the studies using ratios close or equal to the latter figure contained some negative results. Since a 1:1 ratio was unrealistic and the 1:11 ratio less effective than desired, a ratio of 1:6 seems to be the optimum choice. Nineteen Psychiatric Technicians I selected and trained for their assignment could, in conjunction with the original ward personnel, staff a 36-bed ward. This would provide for two shifts of six Technicians seven days per week with necessary relief personnel. An additional person, whom we designate as a Research Analyst, would be required to act as Coordinator of the project under the supervision of the Clinical Psychologist. We would also like to include a Clerk-Stenographer I who might do the necessary recording for this project.

G. Implementation of the Project

1. Selection of Project Staff

a. Selection of Psychiatric Technician I's

Because continuity and consistency of training would be required, we believe that each group of six residents selected must have the continued help of the Technician during their waking hours. This means that for the day, approximately from 6:00 A.M. until 10:00 P.M., it would be necessary to have two shifts of Technicians for six patients. Further, it would be necessary to pursue this project seven days a week. We have therefore determined that it would be necessary, if we are to include needed time off for vacations, sick leave, holidays and weekends, to employ a total of nineteen Technicians.

One eight-hour shift is not sufficient for this kind of a project.

We have determined that Psychiatric Technicians hold the only position in Minnesota Civil Service which could properly be used in this project. It is necessary that we indicate possible employees in this grant application who would fit into Minnesota Civil Service Classification schedules. Since there must be some guarantee of rapport between the workers in this project and the residents who are to profit from it, it is our belief that persons with previous training and experience as Psychiatric Technician I's are needed. We further believe that if this project is to begin at the time that funds may become available, and begin promptly, we must have the personnel ready at the very beginning of the project. The only way we can see to provide this is to select from our present Psychiatric Technician personnel certain persons whom we could believe have the special qualifications needed to carry on this project. Technicians selected for work in the project could be replaced, but if we were to select persons who had had no Technician experience in the past, we would certainly have to embark on a long period of training and orientation which would postpone the effects of the project so greatly needed.

In selecting the Psychiatric Technician I's who would not only be interested in participating in work on the Intensive Training Unit, but who also might be adjudged as good candidates, we would administer the DF Opinion Survey to all present Psychiatric Technician I's. The "DFOS" is an inventory of dynamic factors prepared by J. P. Guilford, University of Southern California; Paul R. Christensen, System Development Corporation; and Nicholas A. Bond, Jr., Sacramento State College. This is a 300-item inventory designed to measure ten general motivational factors. These factors were found in a comprehensive analysis of interest variables. They are said to have general implications for personality as well as being related to broad vocational interests not covered by current interest inventories. The ten factors are as follows:

NA: Need for attention; liking recognition, status, and exhibitionism vs. preference for inconspicuousness.

LT: Liking for thinking; enjoyment of mathematical and logical problems and of planning.

AS: Adventure vs. security; liking for exploration vs. avoidance of dangers.

SR: Self-reliance vs. dependence; responsible and dependable vs. craving support.

AA: Aesthetic appreciation; enjoyment of art in any form--music, literature, drama, and graphic arts.

CC: Cultural conformity; full acceptance of social customs and highly developed conscience vs. rejection of social customs and little bothered by conscience.

NF: Need for freedom; freedom loving, disliking for systems; nonconformist vs. acceptance of controls.

RT: Realistic thinking; matter-of-fact attitude, forthright and direct vs. prone to wishful or autistic thinking.

NP: Need for precision; liking for exactness and detail.

ND: Need for diversion; liking amusement, play, and romanticism vs. realism.

A study of the results of these tests, particularly in the LT, AS, SR, RT, and NP categories, may appreciably help in the selection of the nineteen necessary Psychiatric Technicians for the project.

In addition, interested Technicians will be interviewed and the opinions of Building Charge Technicians and Registered Nurses will be called for in order to particularly determine the applicants' attributes of adaptiveness, interest in working with people, patience, and rigorous attention to detail which may be special qualities needed in this position. We would require that all of the Technicians employed on the project be high school graduates with ability to understand written instructions and to write clear reports.

We regard it as important from a timing point of view that these participants in the project be selected before the project actually begins so that they can go directly to work through an orientation period.

b. Selection of Research Analyst

That there must be very close supervision of the training group is obvious. There must be a detailed breakdown of all areas in which residents' habits must be reconditioned. Each area will require an analysis into

the sub-steps of training required. There must be progression of training as between the sub-steps within the larger areas of habit formations. Supervision, close supervision, will be necessary in order to guarantee that the 36 patients go through all the steps of training necessary. There must be reporting and judgment made whenever a step or sub-step in the training program has been accomplished with any particular patient. There must be overall reports of progress made at least monthly for each patient. Coordination with the other activities of the general staffing unit, with necessities for medical, clinical and dental attention, must be arranged. Participation in larger group activities must be coordinated with the training program. Special problems which deal especially with emotional disturbances must be discussed, with some answer determined in relationship to the training of the patient. We therefore believe that a Coordinator should be selected under the Minnesota Civil Service classification of Research Analyst I. This should be a person with a background of at least college graduation, with an interest in research, with considerable intellectual curiosity and who shows an ability to lead and instruct. He would be called the Coordinator of this project and would report to the Program Director.

The Coordinator will be given a thorough orientation of books on learning theory, research publications and will be provided with a thorough acquaintance of training techniques. Beyond the supervisory aspects of his duties, he will also be instructed in the application of statistical techniques which will enable him to prepare monthly reports of progress and evaluation on the patients in the project. He will consult regularly with the Program Director.

2. <u>The Indoctrination Interval</u>

Following selection, every project employee shall go through an interval of indoctrination for approximately one month. A basic part of the training will involve the acquisition of learning theory. This will refer not only to theories of operant conditioning, but will attempt to review other learning techniques. Films will be introduced to illustrate the technique of operant conditioning, primarily. The method of step-by-step training will be thoroughly discussed. Project personnel will participate in determining the areas of habit readjustment which must become involved in this project. They will participate in a listing of all of the sub-habits that must be learned by the resident in order that he may alter his larger habit areas. Since they have been Psychiatric Technicians in the past, it is very likely that Technicians can make significant contributions in these fields. During the period of orientation, they must come to recognize what they are looking for in the patient which must be changed. The nineteen Technicians, during this period of orientation, must become engaged in a closely directed survey of all 426 patients in the four patient buildings for the purpose of obtaining habit profiles as they presently exist among the patients. From this survey and

as the result of discussions in the orientation period, conclusions will be reached as to which 36 of the patients should be started in the Intensive Training Unit and what various peer groups may be set up to which such trained residents may eventually return with the least likelihood of regression to old habits. It is plain from this that some reorganization of the present membership in the twelve-ward structure of the four buildings may be changed, even from the beginning of the project.

<u>This latter is very important in order to set up some sort of guarantee against regression after the period of training has been carried through by the resident</u>.

It is estimated that approximately one month may be used in this training and orientation fashion which, as noted, will also be a hard working organizational period. It should teach the Technicians that theirs will indeed be an interesting and difficult task.

The Program Director, the Research Analyst (or Coordinator), necessary consultants, and other participants from other parts of our staff will participate in the period of orientation. Other parts of the Psychiatric Technician staff group who are not personally directly involved in the Intensive Training Unit will also receive information as to the findings of the orientation period so that the interest of the whole nursing staff may be developed in the project. It is planned that this kind of a relation will persist throughout the period of the whole project so that its findings with respect to methods of training and the inspiration of its interest may find its way to the rank and file of the whole nursing service.

At the end of the one month orientation period, six residents will be assigned to the care of each Technician and a schedule of daily activities will be provided them. This will include assignments of patients on each of the two shifts and will, as far as practical, afford an assignment of a definite group of six patients to each of the nineteen Technicians, whether they at any one time are on regular shift or on relief. Such assignment is the responsibility of the coordinator and will require very careful scheduling of all Technicians.

3. <u>Selection of Residents</u>

a. <u>Initial Selection</u>

As noted above, during the initial month of employee indoctrination, training will be given in making observations of patient behavior. On assignment to a ward during this time, each employee will be provided with the names of four residents, a kit of play objects to facilitate approach to patients, and a check list by which he may help determine the resident's developmental level in all aspects of

self care, imitative ability, verbal understanding, emotional reaction, and individual characteristics. The latter category includes the pack rats, the food grabbers, the toilet bowl stuffers, the self mutilators or head bangers, the clothes rippers, those with temper tantrums and others. It is hoped that through successive assessments by each employee, all patients within the four buildings will be covered in six assignments.

The next step will be to place the residents into groups which have similar problems or levels of development so that six residents selected from a group can be provided with a specially devised training program for their particular problems. Six groups of six residents will form the initial body of the Intensive Training Ward.

b. Intermediate Selection and Prevention of Regression

As the project continues, regular ratings will provide an index to determine the extent of training absorbable by the resident. When it has been determined that this has been reached, and can be retained, he may be replaced by another resident with similar training needs. The trained resident will be placed on a regular ward with a peer group determined during the orientation work periods, where the resident will, hopefully, continue to be rewarded to maintain his training. Following the return to the usual ward environment, rewards of praise and pats on the back shall be continued to minimize any possibility of slipping back to old behaviors.

Education of the regular Technician staff in the continuation training process is a responsibility of the Coordinator and Program Director.

Since the rate of progression through training will vary with the individual, but the special training given a group remains the same, it will be possible to place an untrained resident into the program at any time.

Because the project plan provides for attention to the patient, continuity of the program can be rather clearly guaranteed.

4. Technique of Progress Evaluation

The Vineland Social Maturity Scale has been the instrument in use for many years as the objective measure of the social maturation of a person. It has also been used in many research projects. In recent years, newer scales of the same design, or modified versions of the Vineland Scale have supplanted the original to match various research designs. A modified scale based upon the Vineland will be taken at regular monthly intervals upon each resident in the program to determine the rate and degree of progress. An individual's accomplishment will be gauged in each of these: self-help general, self-help eating, self-help dressing, self-direction, communication and socialization. Additional items needed to fulfill the criteria of this

project will supplement the original scale to provide a finer index of rate of learning. For instance, the sequence given in dressing skill is: pulls off sox, removes coat or dress, puts on coat or dress unassisted, buttons coat or dress, dresses self except tying, and as a last point, exercises complete care of dress. These are items given in the Vineland Social Maturity Scale. Some items regarded as necessary additions would be: recognizes heel and toe of sock, holds sock in position for foot, pulls on sock, distinguishes front from back of clothes, inserts arm in proper sleeve, matches proper shoe to foot, puts on shoe, puts on hat, puts on glove with correct placement of thumb, and others. Such, or similar items might be added.

Daily progress reports will also be required on each resident in the training program. These will be frequency counts in those areas of training which are identifiable as a single action. A series of single actions done in a step-sequence can thereby lead to the achievement of a simple skill, e.g., refer to the steps identified previously in pulling on a sock. Presentations of these tasks to a resident will be termed a trial and each trial will be recorded as a success or failure. When the criterion of full success is reached and maintained consistently, the next step is introduced, and training is maintained until complete mastery of a task is achieved. The daily records can provide some insight into the effectiveness of the training, the rate of acquisition of these skills by individual residents, and show the need to expand or eliminate the item from the particular training task. In addition to the daily record of this kind, the monthly review of the progress of the patient through a form of the Vineland Social Maturity Scale will be used.

5. The Tentative Ward Program

Along with the training of six selected residents, the goal will be to retain them as a group under all training procedures. The mingling of two or more groups may occur when the training provided does not differ. Such decisions in scheduling are the responsibility of the Coordinator. To illustrate, it may be assumed that the groups selected may vary in dressing training, so that completion of this task by one group occurs at a time earlier or later than in the other groups. They are consequently ready for the next training, in a related but different area, e.g., eating habits. Such group is brought to the dining room ahead of or between other groups, so that they eat with a minimum of distraction from other sources. Insofar as possible, each group will be engaged in a different activity at any moment during a day except to combine them for special events, such as provided by music recreation (rhythm sticks), or play activation, or scheduled rest intervals. Conformity with the regular hospital medical policy of visits to physicians, dentist or prescribed treatment on ward, or any condition which may temporarily remove a resident from his group will fall under the jurisdiction of the regular ward staff.

The schedule for a routine day may appear as follows for a particular group:

6:00 A.M. Residents awakened and individually taken (or sent, depending upon degree of toilet training) to bathroom. rewarded if elimination occurs.

6:20 A.M. Dressing training begins. Desired actions are rewarded.

7:00 A.M. Residents helped to complete dressing. Medication administered.

7:15 A.M. Escorted to bathroom. Hand washing and shaving training started.

7:45 A.M. Taken to breakfast. Eating training.

8:15 A.M. Toileting and teeth brushing.

8:45 A.M. Bath or shower training. (With training in dressing and undressing again)

9:30 to 10:30 A.M. Activation (Type activation dependent on group)

10:30 A.M. Toileting. Rest interval.

11:00 to 11:15 A.M. Prepare and administer medications.

11:30 A.M. Hand washing for noon meal

11:50 A.M. Dinner. Eating training.

12:30 P.M. Play activities. (Trainers combine groups so that they are able to eat).

1:30 P.M. Rest or sedentary activities with social interaction stressed.

2:30 P.M. Sensory training (word association and recognition; correct identification of simple objects rewarded).

3:00 P.M. Music and thythm training.

3:30 P.M. Command training. (Reward for following simple instructions or performing simple tasks.)

4:00 P.M. Toileting - administration of medication.

4:30 P.M. Hand washing

4:45 P.M. Supper - eating training.

5:45 P.M. Rest or television program.

6:00 P.M. Undressing, bath or shower, or toy playing time.

7:00 P.M. Prepare for bed. Undressing training, and put on night clothes.

7:30 P.M. Snack and medication administered. Teeth brushing, face and hand washing training.

8:30 P.M. Toileting.

9:00 to 10:00 P.M. Go to bed.

Residents included in the Intensive Training Group will be given the joint reinforcement of food or object, verbal and tactual reward. As completion of a phase occurs, the verbal-tactual reward is continued, but food or object reward is transferred to successes in the following step. When an act is mastered (e.g., putting on or buttoning a shirt), this brings an end to the food or object reward which is transferred to the mastery of the next higher skill; perhaps putting on or buckling a belt.

The resident will be retained under training as long as there is improvement. If, theoretically, the resident masters all aspects of training, then only verbal reinforcement should be necessary. It is expected that some regression will occur, but with continued stimulation regression should be curbed.

Upon decision that the resident has reached capacity, verbal reinforcement will be substituted for approximately one month, and the resident then returned to a ward with others of comparable development. Other residents may then be placed in the training groups, or new groups started.

6. Where the Training Program Will Occur

A variety of training areas must be provided for the project with use of areas being determined for appropriateness to the training exercise. The following areas are listed:

a. The bed areas of the training ward.
b. The Dayroom, washroom, toilet area and shower rooms of the training ward.
c. The all-purpose room (education room) of the building.
d. The basement recreation hall.
e. The building cafeteria.
f. Applicable areas of the School Department and Rehabilitation Building (Building #4.)
g. That part of the second floor of the Administration-Hospital Building (Building #1) presently being used for demonstration purposes by the Nursing Education Department.

H. Relation of the Project to Minnesota State Planning for the Retarded.

This project is aimed toward implementation of planning begun at the Lino Lakes meeting of the Administrators and Medical Directors of the state institutions for the retarded in 1964. This meeting set forth the new approaches to resident care listed on pages 24 and 25 of this application. There is a direct relationship between this official statement of organization and program planning and the aims of this project for Program 5, the Adult Motivation Program. Pages

28-31 of this application define more thoroughly the mechanism of program development. The proposals of this application to provide for behavioral modification of the adult severely and profoundly retarded through habit training are a definite additive phase in the implementation of the Lino Lakes planning for this large group of patients in Minnesota state institutions for the mentally retarded.

IV Biographical Sketches of Professional Personnel Having Supervisional Relationships to Proposed Project.

A. Harold Phillips Robb, Medical Director

B. Birthdate - 26 November 1924

C. Place of Birth - Wishaw, Lanarkshire, Scotland

D. Citizenship - British

E. Sex - Male

F. Education and experience

1. Graduated M.B. Ch.B. - December 1951
Aberdeen University
Scotland

Diploma of Psychological Medicine - June 1960
Royal Colleges of Physicians and Surgeons of London

2.

Jan. 1952 - Aug. 1952:	HOUSE PHYSICIAN - Aberdeen Mental Hospital
Aug. 1952 - Mar. 1953:	HOUSE PHYSICIAN - Ward Psychiatry, Aberdeen Royal Infirmary
Mar. 1953 - Nov. a953:	HOUSE OFFICER - Out Patient Department, Aberdeen Royal Infirmary
Nov. 1953 - Nov. 1959:	JUNIOR HOSPITAL MEDICAL OFFICER - Ladysbridge Hospital, Banff Bilbohall Mental Hospital, Elgin, Scotland
Nov. 1959 - Jan. 1961:	DEPUTY MEDICAL SUPERINTENDENT Aycliffe Hospital, Darlington, England
Jan. 1961 - Apr. 1963:	CONSULTANT PSYCHIATRIST - Lea Hospital Brownsgrove DEPUTY MEDICAL SUPERINTENDENT Lea Castle Hospital, Kidderminster
Apr. 1963 - Aug. 1965	DIRECTOR OF CLINICAL PROGRAMMING Brainerd State School and Hospital Brainerd, Minnesota
Aug. 1965 - present:	MEDICAL DIRECTOR Brainerd State School and Hospital, Brainerd, Minn.

G. Field of present major professional interest:

1. Social Rehabilitation of the Mildly Retarded.
2. Trainability of the Moderately Retarded.

Biographical Sketch

A. David Willenson, Chief Psychologist

B. Birthdate - 7 May 1920

C. Place of Birth - Milwaukee, Wisconsin

D. Citizenship - American

E. Sex - Male

F. Education and experience

1. University of Iowa, Iowa City, B.A., 1949
Columbia University, New York City, N.Y., M.A., 1950
University of Houston, Houston, Texas, Ph.D., 1959

2. New York Brain Research Project, 1948-49, Psychological Research Assistant
University of Maryland Medical School, 1950-51, Assistant Research Psychologist
Letchworth Village, Thiells, N.Y., 1953-1956, Clinical Psychologist.
State Colony & Training School, Pineville, La., 1959-60, Psychologist II
Brainerd State School and Hospital, Brainerd, Minnesota, Nov., 1960-present, Psychologist III

G. Clinical Psychology in the field of mental retardation.

Biographical Sketch

A. Harold W. Peterson, Administrator

B. Birthdate - 9 December 1904

C. Place of Birth - Rush City, Minnesota

D. Citizenship - American

E. Sex - Male

F. Education and experience.

1. Bachelor of Science, University of Minnesota 1926
Master of Hospital Administration, University of Minnesota 1952.

2. 1926-27 High school teacher of social science, debate coach. Wakefield, Michigan.
1927-43 Senior high school teacher of social sciences, debate coach, Principal of Evening School
1943-50 Department of Defense, Territory of Alaska: Several supervisory positions, ending with Troop Information and Education Officer, Port of Whittier.

1950-52 University of Minnesota School of Public Health, Graduate Study in Course in Hospital Administration; Administrative Resident 1951-52, Mount Sinai Hospital, Minneapolis, Minnesota.

1952-53 Administrator, Hospitals at Hallock and Karlstad, Minnesota; Kittson War Veterans' Memorial Hospital and Karlstad Memorial Hospital.

1953-58 Administrator, Northwestern Hospital, Thief River Falls, Minnesota.

1958-November 1, 1960 - Acting Chief Executive Officer, Brainerd State School and Hospital. (Under Civil Service Classification of Assistant Hospital Superintendent).

November 1, 1960 to present - Administrator, Brainerd State School and Hospital, Brainerd, Minnesota

G. Field of present major professional interest:

Administration in the area of state mental institutions.

H. Supplemental Information:

Active member of the American Association on Mental Deficiency

Member, Board of Directors, Minnesota Hospital Association, 1958-63

President-Elect, 1963-64, Minnesota Hospital Association.

President, 1963-64, Mental Hospital Administrators' Study Group.

Author: "Project to Determine Quantitative, Qualitative and Relational Aspects of Use of Mentally Retarded Patients in the Work of Nursing Services at the Three Minnesota State Institutions for the Retarded": A research project under the supervision and authority of the Medical Services Division, State of Minnesota, Department of Public Welfare, Dec. 1964

V Reasonable Expectations of the Project

In finally suggesting the implications of this project, we envisage the following results as having reasonable probability:

A. That there will be improvement of behavioral patterns among over four hundred adult severely and profoundly retarded residents of this institution.

B. That techniques of training for this type of resident will become known, understood and practiced throughout all treatment programs of this institution insofar as applicable.

C. That resulting improvement of residents' behavioral pattern will favorably affect the morale of Psychiatric Technicians. The effect of the program should reduce the time spent by Technicians on custodial care activities and increase their motivational services to individual patients.

D. That publishable results of this training program may have valuable influence upon similar programs in other state institutions for the retarded.

PATIENT'S NAME: _____ Bldg & Ward _____ ADDENDUM 1 Date: _____

Sex:
- Male _____
- Female _____

Physical Condition:
- Healthy _____
- Frail _____
- Total Care _____
- Mongoloid _____
- Microcephalic _____
- Hydrocephalic _____

Physical Handicap:
- Diabetic _____
- Epileptic _____
- Cardiac _____
- Others _____

Stability:
- Stable _____
- Unpredictable _____
- Confused _____
- Abusive _____
- Aggressive: Self _____
- Aggressive: Other _____
- Hyperactive _____
- Passive _____

Peculiar Behavior:
- Hallucinates, or other psychotic symptoms. Describe:

_____

_____

_____

_____

Uncooperative:
- Most of time _____
- Occasionally _____

Speech-Hearing-Sight:
- Mute _____
- Speech Difficulty _____
- Blind, or partially blind _____
- Deaf, or hard of hearing _____

Degree of Self-care:
- Wheelchair _____
- Ambulatory _____
- Bedfast _____

Bathing:
- Must be bathed _____
- Able to bath self _____
- Needs supervision for bathing _____

Dressing:
- Able to dress self _____
- Must be dressed _____
- Needs supervision in dressing _____

Toileting:
- Completely trained _____
- Partially trained _____
- Incontinent _____
- Urine _____
- Feces _____

Feeding:
- Feeds self _____
- Must be fed _____
- Food Grabber _____

Sleeping Habits:
- Sleeps well _____
- Occasionally awake _____
- Awake most of the night _____

Medication:
- Describe: _____

_____

_____

_____

_____

Special Interest or Abilities:
- Describe: _____

_____

_____

_____

_____

_____

ADDENDUM 2

PROGRAM 5

Technician's Time Schedule

Please take a typical work week of 40 hours and estimate the hours spent in the various tasks (plus fraction when necessary) and place that figure on the line beside the task. For example, if shoe tying was included, and you figured it used 1¼ hours of your daily time, then 6¼ (1¼ x 5 working days) would be filled in. Another duty may only use a fraction of an hour weekly, so whatever that fraction may be (3/4, 5/6, 2/5) would be entered. The sum of these figures should equal 40. Coffee break time may be included as part of the work time of the closest task. While as many tasks as could be thought of were listed, there are probably some which have been missed. Blank spaces are provided to fill in these duties and indicate the work hours they require.

This report is to be used for statistical purposes ONLY. The information you give in no way reflects your personal efficiency, or affects your employment in any way so try to give as accurate a report as possible. Fill in 0 where this task is not a part of your work. Look over all the tasks carefully before assigning hours to them, or use a light pencil with a very good eraser.

Name: Duty Hours:

Bldg. Number: Technician I or II (circle)

Task	Hours
Bathing	6.29%
Dressing	6.77%
Hand Washing	3.77%
Feeding	12.38%
Toileting	3.57%
Personal Grooming (Brush or comb hair, tooth brushing, clean & cut nails, clean and change after soiling, first aid for cuts and bruises)	8.08%
Supervision (work patients, aides, others)	7.02%
Escorting patients (physician, dentist, x-ray)	1.29%
Patient Activation Within Building	4.69%
T.P.R's	1.41%
Attend Meetings (all)	1.33%
Sort and Pass Out Meds	8.16%
Fill out requisitions (clothing order, medication, repair, supplies, etc.)	2.71%
Charting	8.08%

PROGRAM 5

Technician's Time Schedule

Task	Hours
Scheduling	0.58%
Errands (Pick up supplies, delivery, etc.)	0.94%
Laundry & Linen (counting, sorting, etc.)	4.02%
Preparing patient for leave (Packing, dressing, etc.)	2.15%
Conversation with parents, visitors, administrative medical staff	2.10%
Answering the telephone	1.87%
Personal attention to individual patients on ward other than custodial care (solving problems, consoling, training, etc.)	3.77%
Other tasks (fill in)	
Include: Checking patient for needed medical attention, rounds w/R.N. Supervisor, putting patients to bed, hourly check on patients at night, making bath rolls, filling out time sheets, putting clothing room in order, cleaning certain areas, quieting patients and putting back in bed, etc.	9.02%
TOTAL	100.00%